



# Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescription drug at retail cost and are seeking reimbursement. Please include the following:

- This completed form.
- The pharmacy receipt / monograph that came with your prescription (including name of the medication(s), quantity, days supply, strength, NDC number, date, and pharmacy).
- The original register receipt showing method of payment.

Photocopies of the receipts are not satisfactory evidence of purchase. You may need to contact your pharmacy for the necessary information. Retain copies of all your supporting documentation for your records, as submitted documentation cannot be returned.

Card Holder Information			
Employer		Card Holder ID	
Last Name	First Name	Middle Name	Date of Birth
Email Address	Primary Phone	Alternate Phone	
Mailing Address	City	State	Zip

I CERTIFY THAT MEDICATION(S) DESCRIBED HERIN WERE RECEIVED BY THE PATIENT FOR WHOM THIS CLAIM IS MADE AND THAT THE NAMED PATIENT IS A COVERED PERSON IN THE PRESCRIPTION DRUG PROGRAM AND THAT THE PRESCRIPTION IS FOR THE SOLE USE OF THAT NAMES PATIENT. I ALSO CERTIFY THAT THE CLAIM BEING SUBMITTED FOR PAYMENT IS NOT ELIGIBLE FOR PAYMENT UNDER A NO-FAULT OR INDEMNITY AUTOMOBILE OR WORKER'S COMPENSATION INSURANCE PLAN OR PROGRAM. I ALSO AUTHORIZE RELEASE OF ALL INFORMATION PERTAINING TO THIS CLAIM TO THE PLAN ADMINISTRATOR, THEIR REPRESENTATIVE(S), UNDERWRITER(S), SPONSORED POLICY HOLDER, AND/OR EMPLOYER. THE UNDERSIGNED ALSO AUTHORIZES USE OF THE MEMBER IDENTIFICATION NUMBER (CARD HOLDER ID) FOR IDENTIFICATION PURPOSES AND FURTHER RECOGNIZES THAT REIMBURSMENT WILL BE PAID DIRECTLY TO THE PLAN PARTICIPANT AND ASSIGNMENT OF THESE BENEFITS TO A PHARMACY OR OTHERWISE IS VOID.

(CARD HOLDER/AUTHORIZED REPRESENTATIVE) \_\_\_\_\_

Patient Information	
Relationship of Patient to Card Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Student <input type="checkbox"/> Other	Date of Birth
Last Name	First Name
Middle Name	Patient Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

**IMPORTANT INFORMATION ABOUT YOUR CLAIM**

- All restrictions, exclusions, pre-authorization requirements, and limits that your employer and/or insurer have defined for your Prescription Drug Plan apply to all claims for direct member reimbursements.
- Reimbursement is based on the plan and pharmacy-contracted rate and maximum payment amount for the medication(s) or therapeutic class(es) to which the medication(s) belong and may be less than the actual cash or retail price paid.
- Submit this form as soon as you have filled your prescription(s). Claims older than one year from the date the prescription was dispensed will not be reimbursed.
- Incomplete forms or forms with incorrect information may delay payment or cause the form to be returned to you. Please complete the form in its entirety and make sure all requested information is correct.
- Submit a separate claim form for each patient.
- Please allow 6-8 weeks for processing.
- If you have any questions or concerns regarding your claims, please email [help@ptrx.com](mailto:help@ptrx.com) or call 1-877-4MY-PTRX (1-877-469-7879).

**PLEASE MAIL COMPLETED FORM, PHARMACY RECEIPT, AND ORIGINAL REGISTER RECEIPT TO:**

**PTRx, Inc.**  
**c/o Reimbursement Department**  
**P.O. Box 6286**  
**San Antonio, TX 78209**