LucyRx

Prescription Drug Reimbursement Form

Complete all information. An incomplete form may delay your reimbursement.
Medication not covered by benefit will not be reimbursed.

See your prescription ID card.

Group No.

Member ID

Health Plan Name

Member Name (First, Last)

Street Address

City State ZIP

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Sex
- Female
- Male

Relationship to Plan Member
- Self
- Spouse
- Eligible Child
- Dependent Student
- Disabled Dependent
- Dependent Parent
- Nonspouse Partner
- Other

Pharmacy Information

Name of Pharmacy

Street Address

City State ZIP

Telephone (include area code)

Is this an on-site nursing home pharmacy? Yes No

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide LucyRx reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X
Signature of Pharmacist or Representative (Required)

NABP Number Required

Direct Reimbursement Claim Instructions

Read carefully before completing this form.

1. Always present your prescription drug ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid full price for a prescription drug order at a pharmacy because:
   - The pharmacy does not accept your LucyRx prescription drug ID card, or
   - You have not received your LucyRx prescription
3. You must complete a separate claim form for each pharmacy used and for each patient.
4. You must submit claims within 1 year of date of purchase or as required by your plan.
5. Be sure your receipts are complete. In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
6. The plan member should read the acknowledgment carefully, and then sign and date this form.
7. Return the completed form and receipt(s) to:

LucyRx
7815 N. Palm Ave
Suite 400
Fresno, CA 93711

Check the appropriate box if any receipts or bills are for a:

Compound prescription
Make sure your pharmacist lists ALL the VALID NDC numbers, cost and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete. One claim form per compound submission.

Medication purchased outside of the United States
Please indicate:

Country

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. *By completing this form, I recognize that reimbursement will be paid directly to me and that assignment of these benefits to a pharmacy or any other party is void.**

X
Signature of Member

Date

Claim Receipts

Please attach receipts here. If you have additional receipts, tape them on a separate piece of paper.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

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- Amount paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Rx #		Date filled		Days' supply	

VALID 11-digit NDC #	Quantity	Price
Total quantity		
Total charge		

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.