

Prescription Drug Reimbursement Form

Need a Prescription Reimbursement?

Please fill out this form completely to avoid delays.

Note: Medications not covered by your plan are not eligible for reimbursement

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 Relationship to Plan Member

Female	Self	Disabled Dependent
Male	Spouse	Dependent Parent
	Eligible Child	Nonspouse Partner
	Dependent Student	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.

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 on the next page. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
6. Please 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.**

Signature of Member _____

_____ Date

