Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. Submit this form with the original prescription label receipt(s). Cash register and credit card receipts alone are not acceptable as proof of purchase. Reimbursement is not guaranteed. Claims will be subject to limitations, exclusions, and other provisions of the Plan Benefit.

Directions

1. This form must be completely filled out to process your claim(s)
2. Attach a copy of all prescription receipt(s) to the back of this form
3. Please submit within 3 years from the date the prescription was obtained
4. Prescription receipts should contain as much of the following information as possible;
   a. Prescription number and date filled
   b. Pharmacy name and telephone number
   c. Drug name and strength
   d. Quantity, day supply, and amount paid
5. Mailed: OR Faxed:
   Mass Advantage **888-904-1139**
   P.O. Box 1285
   Maryland Heights, MO 63043
6. If you have any questions please contact us, Mass Advantage, at 844-918-0114 (HMO), 844-915-0234 (PPO), TTY users call 711. We are available October 1 - March 31, 8AM – 8PM Eastern, 7 days a week; April 1 - September 30, 8AM – 8PM Eastern, Monday through Friday.

Member Information

Member Full Name:		Member ID Number:
Mailing Address:		Phone Number:
City:	State:	Zip:

You did not receive coverage at the pharmacy because (select at least one):

	You have not received your ID Card
	The pharmacy is not in the retail network
	The pharmacy cannot process the claim electronically
	It was an emergency - Please describe the emergency on a separate sheet
	The pharmacy or payer system was down
	You did not have your ID card and the pharmacy could not verify eligibility
	There were not any network pharmacies available where the prescription could be filled
	Other - Please describe on a separate sheet

Other Insurance Coverage Information
Are you eligible for primary prescription drug coverage from another insurance company?
Yes
No
Other Insurance Company's Name:
Group Number:
Member ID Number:
Effective Date of Coverage:

Prescription Information

#	Rx Number	NDC Number	Compound Y/N	Date Filled (mm/dd/yyyy)	Drug Name/Strength	Amount Paid	Quantity/Day Supply
1							
2							
3							
4							

Pharmacy Information

#	Pharmacy Name	Pharmacy Phone Number	Pharmacy NPI Number
1			
2			
3			
4			

Prescriber Information

#	Prescriber Name	NPI Number	Phone Number	State
1				
2				
3				
4				

REMINDER: To avoid having to submit a paper claim

- ✓ Always have your prescription drug card at the time of purchase
- ✓ Always use pharmacies in your network
- ✓ Use medication covered under your formulary

I certify that the patient for whom this claim is made is a covered person in this Prescription Drug Program and that the prescription is for the sole use of the named patient.

Member's/Subscriber's Signature ______________________________ **Date:** ________________