

# 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.

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## Instructions

This form must be completely filled out to process your claim(s). Attach a copy of all prescription receipt(s) to the back of this form. Please submit **within 3 years** from the date the prescription was obtained. Prescription receipts should contain as much of the following information as possible:

1. Prescription number and date filled
2. Pharmacy name and telephone number
3. Drug name and strength
4. Quantity, day supply, and amount paid.

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## Contact Information

Please submit these items to Mass Advantage, P.O. Box 1285, Maryland Heights, MO 63043 or fax to 888-904-1139.

If you have any questions please contact Member Services — HMO: 1-844-918-0114, PPO: 1-844-915-0234 (TTY: 711); October 1 – March 31, 8 a.m. - 8 p.m. EST, 7 days a week and April 1 – September 30, 8 a.m. - 8 p.m. EST, Monday – Friday. Information is also available through our site at [MassAdvantage.com](https://www.massadvantage.com).

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## 1 Member Information

Member Name

Member ID

<input type="text"/>	<input type="text"/>
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Address (include Suite #)

<input type="text"/>
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City

State

Zip

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Phone Number

Email

<input type="text"/>	<input type="text"/>
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**2 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

**3 Other Insurance Coverage Information**

Are you eligible for primary prescription drug coverage from another insurance company?  Yes  No

Other Insurance Company's Name Effective Date of Coverage

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Member ID Number Group Number

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**4 Prescription Information**

	Rx Number	NDC Number	Compound Y/N	Date Filled (mm/dd/yyyy)	Quantity/Day Supply
1					

Drug Name/Strength	Amount Paid

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

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

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

## 5 Pharmacy Information

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

## 6 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

### Signature

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.

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Member's/Subscriber's Signature

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Date