

## DIRECT MEMBER REIMBURSEMENT FORM

Please attach a detailed receipt from the pharmacy. The prescription label receipt(s) must have the following information clearly legible or reimbursement may be delayed or denied: Pharmacy Name / Drug name, strength, and quantity / Prescribing physician's name / Prescription number and date filled / Member paid expense.

PRESCRIPTION FILLED FOR (Member Name):	DATE OF BIRTH (Member DOB):
KELSEYCARE ADVANTAGE MEMBER IDENTIFICATION NUMBER:	
MAILING ADDRESS:	
PLAN NAME (Group Name):	<b>KELSEYCARE ADVANTAGE</b>

**The claim(s) will be returned if the member/subscriber signature is not present.**

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. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

**MEMBER/SUBSCRIBER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**All reimbursements are subject to plan terms and conditions and may be reduced from the submitted amounts based on plan cost and copayments. Any reimbursement due will be refunded to the policy holder.**

Please check one of the following reimbursement request reasons:

- |  |  |
|--|--|
| <input type="checkbox"/> Non-contracted pharmacy<br><input type="checkbox"/> Eligible member/group invalid<br><input type="checkbox"/> Paid lower co-pay thru pharmacy discount program / Apply to TrOOP<br><input type="checkbox"/> Coordination of Benefits (secondary coverage)<br><input type="checkbox"/> No identification card or identification number available<br><input type="checkbox"/> Other; Please attach a detailed explanation to be considered for reimbursement. | <input type="checkbox"/> Compound Medication<br><input type="checkbox"/> Vacation supply |
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**Fax to:**  
1-888-341-8583

**Mail to:**  
Catalyst Rx  
Direct Member Reimbursement  
PO Box 1069  
Rockville, MD 20849-1069

For questions regarding how to complete this form or the status of your claim, please call Catalyst Rx Customer Service toll-free at: 1-866-589-5222, TTY/TDD: 1-888-206-8041.