

MEMBER INFO

Rx Group #: (8 DIGITS) Group Name: _____

Member ID #: (INCLUDE ZEROS. MAY NOT USE ALL SPACES.)

Name: _____

Address: _____

City: _____ State: ZIP Code:

Phone: -- Home Work Cellular

Patient Name: _____

Date of Birth: // Person Code:

INSTRUCTIONS

Use this form for prescriptions that were purchased outside of the United States.
 Note: You are not eligible for reimbursement pursuant to federal regulations if;

- i.) You traveled to a foreign country solely for the purpose of re-importing prescription drugs into the United States and/or;
- ii.) You used other means to ship/bring medications from a foreign country into the United States. You will be reimbursed directly for covered services up to the contracted amount.

- Use a separate form for each patient.
- Include all prescription receipts (with prescription detail clearly noted).
DO NOT staple or tape to paper. Mail to the address shown at the bottom of this form.
- Incomplete forms will be returned for additional information without payment.
- Cash register or credit card receipts are not valid for processing.
- Retain a copy of the pharmacy receipt(s) for your own records.
- Benefits are payable directly to the CARDHOLDER and are NOT ASSIGNABLE to pharmacies.
- Please call us at **1.800.382.8132** with questions or for assistance filling out this form.

PRESCRIPTION 1

Date prescribed: // Physician Name: _____

Date filled: // Rx Number: _____

Pharmacy Name: _____

Quantity: Drug Name and Strength (Foreign): _____

Days Supply: Drug Name and Strength (English): _____

Doctor prescribed medication to treat: _____

Country (where drug was purchased): _____

Exchange rate on date of purchase: _____

Amount paid (in US dollars): \$

PRESCRIPTION 2

Date prescribed: MM/DD/YYYY

Physician Name: _____

Date filled: MM/DD/YYYY

Rx Number: _____

Pharmacy Name: _____

Quantity: [][] Drug Name and Strength (Foreign): _____

Days Supply: [][] Drug Name and Strength (English): _____

Doctor prescribed medication to treat: _____

Country (where drug was purchased): _____

Exchange rate on date of purchase: _____

Amount paid (in US dollars): \$ [][][][] . [][]

PRESCRIPTION 3

Date prescribed: MM/DD/YYYY

Physician Name: _____

Date filled: MM/DD/YYYY

Rx Number: _____

Pharmacy Name: _____

Quantity: [][] Drug Name and Strength (Foreign): _____

Days Supply: [][] Drug Name and Strength (English): _____

Doctor prescribed medication to treat: _____

Country (where drug was purchased): _____

Exchange rate on date of purchase: _____

Amount paid (in US dollars): \$ [][][][] . [][]

SIGNATURE

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- Expense was incurred for prescription(s) received by me or my eligible dependents under the plan.
- Expense was for prescription(s) furnished on or after the effective date of my plan.
- I have not been reimbursed for listed prescription(s) in any other way or from any other source.
- I did not travel outside of the United States solely for the purpose of re-importing prescription drugs nor did I use other means to bring/ship medications into the United States against federal regulations.

Signature of member

Date

A person who knowingly files a claim containing false or misleading information is subject to criminal and civil penalties.