

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 a separate form for each patient.
- Include all pharmacy receipts (providing details on medication name, prescription number (Rx#), National Drug Code (NDC), quantity, days supply and amount paid). **DO NOT staple or tape receipts to prescription reimbursement form.** Retain a copy of the pharmacy receipts for your own records. Cash/credit register receipts are not valid for processing.
- Mail prescription receipts and completed reimbursement form to:
Innoviant, P.O. Box 8082, Wausau, WI 54402-8082
- Incomplete forms will be returned for additional information without payment.
- A person who knowingly files a claim containing false or misleading information is subject to criminal and civil penalties.
- Benefits are payable directly to the MEMBER and are NOT ASSIGNABLE to pharmacies.
- For further assistance, or if you need help filling out this form, please call us at **1.877.559.2955**.

DETAILS

Reason for Reimbursement (check only one of the following):

- Patient did not receive card before time of purchase
- Card was not with the patient at the time of purchase
- Card was lost or stolen
- Pharmacy does not honor the Innoviant Prescription Program
- Patient is a COBRA participant
- Coordinate benefits with other insurance company
- Claims already processed by Medicare Part D carrier; submitting for secondary coverage
- Other _____

SIGNATURE

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

- They were incurred for prescriptions received by me or my eligible dependents under the plan.
- They were for prescriptions furnished on or after the effective date of my plan.
- I have not been reimbursed for these prescriptions in any other way or from any other source (except Medicare Part D).

Signature of member

Date