PRESCRIPTION DRUG CLAIM FORM

DIRECT MEMBER REIMBURSEMENT

Mail this form along with receipts to:
Navitus Health Solutions®
P.O. Box 999
Appleton, WI 54912-0999
OR
Fax this form along with receipts to:
(920) 735- 5315

Use this form for prescriptions that were purchased without using your ID card, purchased in relation to an emergency room visit or purchased after you submitted your claim to a primary insurance carrier. Compound drugs must be submitted using the Navitus Compound Drug Claim Form.
NOTE: Reimbursement will be made directly to the CARDHOLDER, unless otherwise noted.
Claim submission is not a guarantee of payment. Reimbursement is subject to plan benefits.

Cardholder Name:	**Cardholder #:**		
Cardholder Address:	**City:**	**State:**	**Zip:**
Group # (RxGrp):	**Group Name (RxPCN):**		
Patient Name:	**Patient ID # :**	**Patient Date Of Birth:**	
Relationship of Patient to Cardholder: __ Self __ Spouse __Child __Other		**Patient's Gender: __ Female __ Male**	

Does Patient have other drug coverage: __Yes __No
If yes, and other insurance *is* Medicare, attach a copy of the Medicare Explanation of Benefits (MEOB).
If yes, and other insurance *is not* Medicare, include denial notification from the primary insurance carrier or pharmacy printout.

PRESCRIPTION/ OTHER INSURANCE INFORMATION:

THIS SECTION MUST BE COMPLETED BY YOU OR YOUR DISPENSING PHARMACIST. PRESCRIPTION RECEIPTS OR PHARMACY PRINTOUTS MUST BE ATTACHED; SALES RECEIPTS WITHOUT PHARMACY DETAIL WILL NOT BE ACCEPTED. RECEIPTS CANNOT BE RETURNED. PLEASE KEEP A COPY, IF NEEDED.

 # 1
Pharmacy Name____ **Address**____

Rx Number___________________________ **Drug Name & Strength**____ **NDC #**________________________

Original Date of Rx ____________________ **Date Filled**__________________ **Quantity**___________________________ **Days Supply** _________________

Physician Name ____________________________________ **Physician NPI # (if available)** ___________________________

Other Insurance Company Name ________________________________ **Other Insurance Phone Number** _________________________________

Original Cost of Rx $_______ **Amount Primary Insurance Paid on Rx $**_______ **Patient Paid Amount $**_______ **Vaccine Admin Fee $**______

 # 2
Pharmacy Name____ **Address**____

Rx Number___________________________ **Drug Name & Strength**____ **NDC #**________________________

Original Date of Rx ____________________ **Date Filled**__________________ **Quantity**___________________________ **Days Supply** _________________

Physician Name ____________________________________ **Physician NPI # (if available)** ___________________________

Other Insurance Company Name ________________________________ **Other Insurance Phone Number** _________________________________

Original Cost of Rx $_______ **Amount Primary Insurance Paid on Rx $**_______ **Patient Paid Amount $**_______ **Vaccine Admin Fee $**______

PLEASE SIGN AND DATE HERE: I CERTIFY THE ABOVE INFORMATION IS CORRECT, AND THE PRESCRIPTIONS LISTED ABOVE ARE FOR ME OR FOR ELIGIBLE MEMBERS OF MY FAMILY WHO HAVE RECEIVED THE MEDICATION DESCRIBED ABOVE. I AUTHORIZE RELEASE OF ALL INFORMATION CONTAINED ON THIS CLAIM TO NAVITUS AND MY PLAN SPONSOR.

SIGNATURE: ____ DATE SIGNED: ____

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.

INCOMPLETE FORMS WILL BE RETURNED FOR ADDITIONAL INFORMATION WITHOUT PAYMENT.