

Prescription Claim Reimbursement Form



For claim reimbursement, complete and mail or this form to US Script, 2425 W. Shaw Ave., Fresno, CA 93711. Forms can also be faxed to (559) 244-3793. **Incomplete forms will delay processing.** US Script's customer service desk can be reached at (800) 413-7721.

****To be completed by insured. Please PRINT clearly.**

I. MEMBER INFORMATION		II. PRESCRIPTION PLAN INFORMATION	
Member Name:		Insured's Member ID #:	
Address:		Group #:	
Birth Date:	Phone:	Employer:	
III. PATIENT INFORMATION			
Relationship to insured:			
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____			
Is patient covered by any other medical benefit plan, group policy repayment plan, Medicare, or other government plans?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, give the name of the person carrying coverage: _____			
If Yes, name of the alternate coverage (group name, employer, association, etc): _____			
Patient illness or injury (if injury, include a description of the accident, including date and place).			
Did condition result from employment?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, date you last worked prior to treatment for which claim was made: _____/_____/_____			
IV. PRESCRIPTION INFORMATION			
This section must be completed by you or your dispensing pharmacist. One prescription label should be attached for each prescription. Alternately, include a copy of your pharmacy receipt with this form.			
Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled: _____/_____/_____	Quantity:
RX Name & Strength:		Days Supply (30, 60, 90):	
NDC #:	DAW:	Price:	Comments:
Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled: _____/_____/_____	Quantity:
RX Name & Strength:		Days Supply (30, 60, 90):	
NDC #:	DAW:	Price:	Comments:

Please sign and date here: I certify that the above information is correct and the prescriptions listed above are for myself or eligible members of my family who have received the medication described above, and I authorize release of all information contained on this claim form to US Script and my plan sponsor.

Signature: _____

Date signed: _____