Prescription Claim Reimbursement Form

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For claim reimbursement, complete and mail 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:

☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

Is patient covered by any other medical benefit plan, group policy repayment plan, Medicare, or other government plans?

☐ Yes ☐ 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?

☐ Yes ☐ 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:** _____