MCS Life Insurance Company

PRESCRIPTION REIMBURSEMENT CLAIM FORM

In order to process a reimbursement for pharmacy services, you need to fill out the following information:

PATIENT'S NAME:
AFFILIATE'S CONTRACT NUMBER (Printed on plan ID):
POSTAL ADDRESS:
EMPLOYER'S NAME:

Important: Signature is required

Disclosure of information: I hereby certify that I (or my eligible dependent) have (has) received the drug described herein and that the aforementioned plan participant is eligible to receive prescription drug benefits. I also certify that the drug received is not intended to cure a work-related injury and is not covered by any other benefit plan. I hereby authorize the disclosure of all the information related to this claim to {Catalyst Rx} (the prescription drug benefits manager), the insurer, the sponsor, the insured and/or the employer. I hereby certify that all the information provided in this form is correct as well as all the information that is attached to it.

Antifraud Information: The Insurance Code of Puerto Rico, Title 26 of the Annotated Laws of Puerto Rico, Section 2719 established that: “Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If there were aggravating circumstances, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.”

_____ _____

Signature of the plan participant or representative Date

All reimbursements shall be subject to the plan's terms and conditions and may be lower than the amount filed based on the cost of the plan and the copayments.

Services rendered in the United States of America and/or a foreign country:

Claim forms shall be accepted for the payment process along with a detailed receipt that includes: the prescription number, the name of the drug, the amount sold, and the amount paid, per product. For a drug that is sold in a foreign country, all the necessary measures shall be taken to identify the drug sold with drugs in the American market in order to proceed with the reimbursement. Please make sure you receive a receipt with all the information needed to avoid delays.

An official receipt from the pharmacy is needed which you will need to attach to the form. If the following information is not included in the recipt, request that that the pharmacist fill out and sign this form, and to attach the payment receipt to it. Without the required information, {CatalystRx} will not be able to process your claim.

Prescription Number	*Pharmacy's NPI number	Filling Date	Drug name and dose	* NDC number	* DEA number of the prescribing physician	Amount	Supply days	Total Paid

Pharmacist's Signature: _____ Pharmacy's telephone number:_____

THE PHARMACIST'S SIGNATURE IS REQUIRED WHEN A DETAILED RECEIPT IS NOT PROVIDED.

Instructions for Compound Prescriptions: In case of a compound prescription, write down the NDC number of the costliest ingredient of the drug used in the prescription.

COMPOUND PRESCRIPTIONS (MIXTURES)

FOR PHARMACY USE ONLY

NDC number	Name of the ingredient	Amount	Charges

Please return the duly filled out claim form, along with your receipts, to:

{Catalyst Rx
Direct Member Reimbursement
PO Box 100759
Ft. Lauderdale, Florida 33310}

You may send it via fax to: {1-866-854-2610}

*Note to the affiliate: Below are the definitions of some of the required fields in the table.
Make sure to have your receipt on hand when you fill out this document:

NPI Number = *National Provider Indicator*
NDC Number = *National Drug Code*
DEA Number = *Physician Drug Enforcement Administration Number.*