SAVINGS CARD POST-TRANSACTION REIMBURSEMENT

PO BOX 42638 | Cincinnati, OH 45242 | Attn: PTR Processing | Tel: 1-866-923-1953

Please complete this form and submit with all required information and attachments to be considered for reimbursement.
Claims for any prescription covered under Medicare, Medicaid, CHAMPUS, TRICARE® or any state or federally funded programs, nor any amount covered by insurance, FSA, or HSA are INELIGIBLE for reimbursement.

Part I – Patient Information

_____ *Last Name*
_____ *First Name*
_____/_____/_____ *Date of Birth*

_____ *Street Address*
_____ *Apt / Suite No.*
_____ *City*

_____ *STATE*
_____ *ZIP*
_____ *Phone*
_____ *email*

Part II – Medication and Savings Card Information

Please fill in the information below using the printed offer or Savings Card information you received.
Name of drug you are submitting a claim for: _____

RxBIN:	018844
PCN:	###
Group #:	#########
Identification #:	###########

Group #: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Identification # [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Part III – Insurance Information

Do you have Health Insurance: [ ] No [ ] Yes My insurer for prescription benefits is:_____
My insurance covered: [ ] This entire prescription [ ] None of this prescription [ ] All except copay of: $ _____
This prescription was filled: [ ] At a retail pharmacy store [ ] Through mail order or specialty pharmacy

Part IV – Pharmacy Information

_____ *Pharmacy Name*
_____ *Pharmacy Street Address*
_____ *Pharmacy City*

_____ *Pharmacy STATE*
_____ *Pharmacy ZIP*
_____ *Pharmacy Phone*

Part V – Prescriber Information

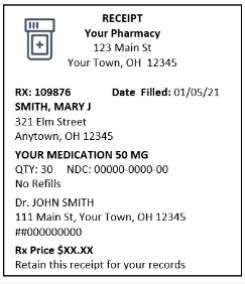
_____ *Physician Name*
_____ *Physician Practice Street Address*
_____ *Physician Practice City*

_____ *Physician Practice STATE*
_____ *Physician Practice ZIP*
_____ *Physician Practice Phone*

Part VI – Claim Submission

Mail this completed form and the information below to:
Savings Card Post-Transaction Reimbursement, PO BOX 42638, Cincinnati, OH 45242, Attn: PTR Processing

1. The **original pharmacy receipt** received from your pharmacy with your prescription which must include: Patient name and address · Pharmacy name, address, and phone number · Doctor or health care provider name, address, and phone number · Rx #, fill date, drug name, strength, NDC #, and quantity · Prescription price and copay amount or out of pocket expense paid.
2. The **original cash register receipt** with the amount paid for this prescription clearly identified.
3. A **copy of your primary insurance card**, including both front and back of the card.
4. A **copy** of your Savings Card offer.


RECEIPT
Your Pharmacy
123 Main St
Your Town, OH 12345

RX: 109876 Date Filled: 01/05/21
SMITH, MARY J
321 Elm Street
Anytown, OH 12345
YOUR MEDICATION 50 MG
QTY: 30 NDC: 00000-0000-00
No Refills
Dr. JOHN SMITH
111 Main St, Your Town, OH 12345
##000000000
Rx Price $XX.XX
Retain this receipt for your records

Part VII – Certification Statement

"I certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred and that they were not and will not be paid by my insurance, my Flexible Spending Account (FSA), Health Savings Account (HSA) or any other payor. I certify that I am not covered under Medicare, Medicaid, TRICARE®, CHAMPUS or any other government (state or federally funded) program and I understand that I am liable for any misrepresentations herein to the full extent of applicable law."

In support of my claim for reimbursement of my pharmacy expenses, I authorize the Company and its agents to contact my pharmacy to disclose information about the pharmacy claim for which I am seeking reimbursement.

A copy of this authorization is as valid as the original, and this authorization will be valid even if I sign it electronically.

Claimant/Patient/Legal Guardian Signature: _____ Date_____

Please allow 4-6 days for processing. Failure to complete in its entirety will result in claim rejection.