



DIRECT MEMBER REIMBURSEMENT FORM

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Member Group # \_\_\_\_\_ Member ID # \_\_\_\_\_  
(These numbers can be found on your prescription card.)

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Patient Phone # \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Pharmacy NABP # \_\_\_\_\_  
(You can get this from your pharmacy.)

Pharmacy Phone # \_\_\_\_\_

Name of Medication \_\_\_\_\_

NDC # of Medication \_\_\_\_\_  
(You can get this from your pharmacy.)

Quantity \_\_\_\_\_ Day Supply \_\_\_\_\_

Total Amount Paid \_\_\_\_\_

Reason for Paper Claim Submission

Did not have prescription card       Pharmacy did not recognize prescription card

On vacation/ out of town       Other \_\_\_\_\_

Please complete this form and attach pharmacy receipts and return it to the address shown below. Please allow up to three weeks for reimbursement. If you have any questions, please do not hesitate to call our toll free number (800) 933-3734.

**Please send claims to:**  
**PharmAvail Benefits Management**  
**Claims Dept.**  
**3380 Trickum Rd., Bldg. 500, 104**  
**Woodstock, GA 30188**