CerpassRx
5904 Stone Creek Drive, Ste.120
The Colony, TX 75056
1-844-636-7506
www.cerpassrx.com

Direct Reimbursement Claim Form

When to use this from:

This claim form is to be used only when you purchased a prescription before you received your CerpassRx identification card, when you purchased a prescription without using your identification card or when you used a non-participation pharmacy. Submit this form as soon as you have your prescription(s) filled in order to receive prompt payment. IT IS NOT necessary to retain the form until you have filled six prescriptions claims.

Instructions:

- The purpose of this form is for you to request reimbursement for your medication that you purchased without using your health plan card or other reasons approved by your health plan.
- In order to process your request within 6-10 weeks after receiving your request, it is important to complete all of the information and documentation requested.
- Please use a separate form for each patient.
- In some instances, it will be necessary to contact the pharmacist to assist in completing the information required by the Pharmacy.
- Your health plan will determine reimbursement due based on your Pharmacy benefit.
- Reimbursements are subject to the terms and conditions of your health plan and the amount may be less than the amount presented less applicable copay.
- Reimbursement will only be considered within the timeframe established by your health plan.

Patient Information
Member ID Number:
Group Number:
Patient Name:
Date of Birth:
Patient Address:
Patient Telephone Number:
Name of Legal Representative (If applicable):

Patient Signature or Legal Representative

Date

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Pharmacy information Section:

Pharmacy NABP	**Rx Number**	**Date Dispensed**	**Quantity**
Day Supply	**Drug Name & Strength**		**Drug NDC (11 digits)**
Physician Name		**Physician NPI**	**Total Paid**

Pharmacy NABP	**Rx Number**	**Date Dispensed**	**Quantity**
Day Supply	**Drug Name & Strength**		**Drug NDC (11 digits)**
Physician Name		**Physician NPI**	**Total Paid**

Pharmacy NABP	**Rx Number**	**Date Dispensed**	**Quantity**
Day Supply	**Drug Name & Strength**		**Drug NDC (11 digits)**
Physician Name		**Physician NPI**	**Total Paid**

Pharmacy NABP	**Rx Number**	**Date Dispensed**	**Quantity**
Day Supply	**Drug Name & Strength**		**Drug NDC (11 digits)**
Physician Name		**Physician NPI**	**Total Paid**

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In order to process your request for reimbursement for your medications, it is necessary that you include the following documents:

- "Pharmacy Information Section"

  - ✓ Drug Name, dose & quantity dispensed
  - ✓ Prescription Number
  - ✓ National Drug Code (NDC)
  - ✓ Amount Paid for the medications
  - ✓ Date Dispensed
  - ✓ Name, Address, Telephone & Pharmacy NPI#
  - ✓ Name & Physician NPI# that prescribed the medication

- The original paid pharmacy receipt(s) must accompany this form. A cash register or charge receipt is not satisfactory, as it does not contain the information noted above. Handwritten receipts are not acceptable.
- If you no longer have original receipt(s) or they do not contain all of the required information, please ask your pharmacy to give you a printout of the claims. Pharmacy printouts are acceptable.
- Please allow 6 to 10 weeks for processing and payment of your claims(s). Claim forms submitted without the required information will be returned and/or will cause payment delay.

If you have any questions, please contact our customer service center at: 1-844-636-7506

Remember to sign the direct reimbursement claim form send orignals forms .

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Fax # (469) 533-9967

Email Forms
manualclaims@cerpassrx.com