



Direct Member Reimbursement Form

INSTRUCTIONS:

- * This form is to provide direct reimbursement for prescriptions that were purchased without the use of your PBM Plus card.
* In order to process your claim(s) in the timeliest manner, you must provide all information requested below.
* Contact your pharmacist, if necessary, to provide the detailed drug information requested. Receipts must be enclosed.
* Do not submit this claim form until you receive your PBM PLUS card (from which you will obtain your identification numbers).
* Please use a separate claim form for each patient. * Do not staple or tape receipts or attachments to this form.

Cardholder ID No: _____ Group No /Group Name: _____
Cardholder Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: () _____

PATIENT Information - Use a separate form for each family member

Patient Name: _____ Date of Birth: _____
Patient Gender: [] Male [] Female Relationship to Cardholder: [] Member [] Spouse [] Child [] Other
Are any of these medications being taken for an on-the-job injury? [] Yes [] No
Were these medications filled at a PBM Plus affiliated pharmacy? [] Yes [] No
If not filled at a PBM Plus affiliated pharmacy, please indicate reason: _____
If filled at a PBM Plus affiliated pharmacy why was full payment made by patient? _____

Is the medication covered under any other group insurance? [] Yes [] No

If yes, is other coverage: [] Primary [] Secondary
If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurer: _____ Policy#: _____ ID#: _____ Phone: () _____

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for drug benefits. I also certify that the medication received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to PBM Plus, Inc., the plan administrator, insurance underwriter, plan sponsor, policyholder and/or employer. I certify that all the information entered on this form is correct.

X _____
Signature of Cardholder or Legal Representative Date

PRESCRIPTION CLAIM INFORMATION REQUIRED: All of the required information should be on the pharmacy receipt.

1 Rx #: _____ Date Filled: _____ Quantity (ml. # tablets, gm., etc.): _____ Days Supply: _____
Month/Day/Year
Name of Medication _____ Dosage (250mg. etc.): _____ Daily dosage: _____
Is this a compound? [] Yes [] No Prescriber DEA# _____ NDC#: _____ - _____ - _____
Prescription Cost: \$ _____ Tax: \$ _____ Total Cost: \$ _____

2 Rx #: _____ Date Filled: _____ Quantity (ml. # tablets, gm., etc.): _____ Days Supply: _____
Month/Day/Year
Name of Medication _____ Dosage (250mg. etc.): _____ Daily dosage: _____
Is this a compound? [] Yes [] No Prescriber DEA# _____ NDC#: _____ - _____ - _____
Prescription Cost: \$ _____ Tax: \$ _____ Total Cost: \$ _____

3 Rx #: _____ Date Filled: _____ Quantity (ml. # tablets, gm., etc.): _____ Days Supply: _____
Month/Day/Year
Name of Medication _____ Dosage (250mg. etc.): _____ Daily dosage: _____
Is this a compound? [] Yes [] No Prescriber DEA# _____ NDC#: _____ - _____ - _____
Prescription Cost: \$ _____ Tax: \$ _____ Total Cost: \$ _____



INSTRUCTIONS FOR SUBMITTING A MANUAL CLAIM

Members who have a prescription filled at an affiliated PBM Plus pharmacy prior to receiving their PBM Plus ID card and who have paid for the prescription are encouraged to take their ID card to that pharmacy and ask the pharmacy to submit the claim to PBM Plus. If the pharmacy is able to process the prescription on line, they may be able to provide a refund, less the applicable co payment, for the amount previously paid. Pharmacies have different computer and financial systems and cannot always accommodate such requests.

Members who have a prescription filled at a non-participating pharmacy or who must pay for their prescription at a PBM Plus affiliated pharmacy may submit such claims to PBM Plus for reimbursement. Payment of such claims and the level of reimbursement are dependent on the specific pharmacy benefit provided to the member by their employer. Certain plans do not provide for any reimbursement for prescriptions not filled at an affiliated pharmacy and others significantly limit the levels of reimbursement. All plans limit such reimbursement to emergency or unusual situations. Members who choose to utilize a non-participating pharmacy on a routine basis will not receive reimbursement.

Members who need to submit a claim to PBM Plus for reimbursement must obtain a Direct Member Reimbursement Form. Other forms cannot be processed. These forms are available at your Human Resources Department or on the Internet at www.pbmplus.com.

To avoid claims processing delays, members should validate that they have followed all instructions and that all information requested on the form is complete and legible. PBM Plus will return all claims that are incomplete or illegible.

1. A separate claim form must be completed for:
 - Each patient
 - Each pharmacy from which prescriptions were received
2. The following information must be included:

• Pharmacy name	Original pharmacy receipts*
• Prescription number	Drug charge
• Date of purchase	Quantity (units, ml, grams)
• Drug name	Drug strength

* Do not submit canceled checks, cash register receipts or personal itemization. These are not acceptable as substitutes for original receipts. (Photo copies of original receipts are acceptable). Do not submit statements with "balance" amounts only.

Complete all cardholder and patient information.

- Cardholder name
- Patient name, date of birth, gender and relationship to cardholder
- Cardholder ID (The cardholder ID number can be found on your ID card)
- Daytime phone number

Please make a copy of all documents and receipts before sending them to PBM Plus. Documents cannot be returned.

Mail the requested information to:

PBM Plus, Inc.
300 TechneCenter Drive, Suite B
Milford, Ohio 45150