

DIRECT MEMBER REIMBURSEMENT FORM

Please attach a detailed receipt from the pharmacy, including all of the following information. If this information is not on the receipt, please have the pharmacist complete and sign this form and attach proof of payment. **Without the required information CatalystRX will not be able to process your claim.**

PRESCRIPTION FILLED FOR:
EMPLOYEE'S IDENTIFICATION NUMBER (Printed on prescription card):
MAILING ADDRESS:
EMPLOYER NAME:

RX #	Pharmacies NABP #	Fill Date	Drug Name	NDC Number	Prescribing Physician/DEA #	Quantity	Days Supply	Amount Paid

PHARMACIST SIGNATURE: _____ **Pharmacy Phone Number** _____
PHARMACIST SIGNATURE IS REQUIRED WHEN A DETAILED RECEIPT IS NOT PROVIDED.

All reimbursements are subject to plan terms and conditions and may be reduced from the submitted amounts based on plan cost and co-payments.

Please check one of the following reimbursement request reasons:

- Member did not have the CatalystRX prescription drug card with them.
- Member did not receive the CatalystRX prescription drug card before the time of purchase.
- Vacation supply
- Claim was rejected at the pharmacy.
- Claim consideration for C.O.B. (secondary coverage)
- Out of network purchase.
- Other; Please attach a detailed explanation to be considered for reimbursement.

Fax to:
888-341-8583

Mail to:
Catalyst Rx
Direct Member Reimbursement
PO Box 1069
Rockville, MD 20849-1069