REALRx

Prescription Reimbursement Request Form

This form is used for reimbursement of pharmacy benefit claims. RealRx members can submit approved expenses for reimbursement using this Direct Member Reimbursement (DMR) form.

Instructions – Please read the information carefully

1. **Complete all information on the form.**
   Incomplete information may result in a delayed payment or may be returned for additional information.
   A separate form is required for each patient.
   Reimbursement claims must be submitted within one year from the date of service.
   Payment and/or communications will be sent to the address in our system unless additional information is on file (ie: legal guardian or appointed representative).

2. **Required Documentation**
   Include the original **itemized pharmacy receipt** for each medication.
   Note: Cash register or credit card receipts cannot be used alone for claim reimbursement.
   An itemized prescription label/receipt includes the following required information:
   - Date of service
   - Medication name, strength and dosage form
   - NDC (National Drug Code) **Compound drugs must include NDC for all active ingredients*
   - Quantity filled and Day Supply
   - Pharmacy name, phone number and address[1]
   - Pharmacy NPI (if available)
   - Prescriber name
   - Prescriber NPI (if available)
   - Amount paid

3. **Submit the completed form and all itemized receipt(s) to the address or fax below.**
   Remember to keep a copy of submitted documentation for your own records.

[1]Reimbursement for medications obtained out of the country require additional review and are limited by the terms of your plan's Foreign Prescription and Out of Network policies.

Contact Us

☎ 855.859.4892

Customer Service is available 24/7/365
Preferred hours are Monday - Friday 8:00 am – 7:00 pm,
Saturday 9:00 am – 3:00 pm MT

✉ RealRx
Attention: Claims Department
PO Box 1308
Sandy, UT 84091

Fax: 385.425.4070

REALRx

Patient Information

Policyholder Name : ______________________ Member ID:______________________

Patient Name: ______________________ Patient Date of Birth: ______________

Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Address:____

City: ______________________ State:__________ Zip:__________

Phone: (______)______________

Number of receipts submitted with this reimbursement:______________________

Does patient have other insurance? ☐ No ☐ Yes If Yes, please provide information ________

____

Reason benefit card was not used at time of fill: ______________________

Additional notes or information regarding this request:

I attest and certify under penalty of law to RealRx that the information provided on this form is complete and accurate. I further understand that reported information may be verified by an audit as deemed necessary by RealRx. I understand that assistance will terminate if RealRx becomes aware of any fraudulent activity. I understand that assistance may be limited to the terms and conditions established by RealRx and that RealRx reserves the right at any time, or for any reason, and without notice to (i) modify this form, (ii) modify or discontinue any or all of the programs and the related eligibility criteria, or (iii) terminate assistance.

I authorize RealRx and its employees, third party administrators, agents and other representatives to obtain information from my healthcare providers, insurance coverage information from my employer or insurance company(ies) as necessary to complete the reimbursement process or to verify the accuracy of any information provided with this form.

Signature:______________________________ **Date:**______________

☑ **Reimbursement request submission checklist:**

- ☐ Form is completed
- ☐ Form is signed and dated
- ☐ Include all itemized pharmacy receipt(s)
- ☐ Submit the completed form and all itemized receipt(s) to the address or fax below

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