



PRESCRIPTION CLAIM FORM

We are pleased to be your prescription plan carrier. Please use the following guidelines when submitting reimbursement requests for medication.

- 1. Complete one form per patient.
2. Your reimbursement request must be received no later than one year from the date the medication is filled.
3. Complete the information below.
4. Write your identification number on the top of each page.
5. Tape your original receipts in the boxes marked for receipts. Receipts must include pharmacy name and address, full name of patient, date filled, quantity, physician name, name of medication or item, prescription number, and charge/copayment. Cash register receipts do not provide enough information.
6. Retain copies of receipts for your records.
7. Sign the completed form where indicated at the bottom of this page and mail to: RxEDO, Inc. P.O. Box 419019, Dept 398 Kansas City, MO 64141
8. Additional forms may be obtained by calling 1 (888) 879-7336.

Identification Number \_\_\_\_\_
Patient's Name \_\_\_\_\_ Employee Name \_\_\_\_\_
Patient's Date of Birth \_\_\_\_\_ Daytime Phone \_\_\_\_\_
Mailing Address \_\_\_\_\_

Is this medication covered under any other group insurance policy? If yes, give name of insurance company and ID number.
\_\_\_\_\_

CERTIFICATION STATEMENT:

I certify that the above information is correct and that the above checked person is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this voucher to my prescription medication plan and the underwriter. I agree that any benefits payable hereunder for prescription medications are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

Signature \_\_\_\_\_ Date \_\_\_\_\_

ID Number \_\_\_\_\_

TAPE RECEIPT HERE  
In date order

TAPE RECEIPT HERE  
In date order

TAPE RECEIPT HERE  
In date order