Prescription Drug Claim Form

You are not required to use this form to request a reimbursement. Please fill out as much information as you have available. If there are any blank fields, we will attempt to obtain the information directly from your pharmacy.

Please indicate the reason for your reimbursement request.

- ☐ I did not have my member ID card at the time of purchase.
- ☐ I was charged for medication(s) received during an urgent care/emergency visit.
- ☐ I was administered a Medicare Part D covered vaccine in my doctor's office.
- ☐ Primary coverage is with another insurance carrier. (Coordination of Benefits)
- ☐ Other: _____

Part 1: Member Information

1. Complete ALL information. Your ID Number can be located on the front of your member ID card.
2. Submit claims within the filing period specified in your Evidence of Coverage. For questions about the filing period, please review your Evidence of Coverage or call Customer Service at 1-844-908-0313 (TTY 711). Hours of operations: 8 am-8 pm 5 days a week (Apr 1st - Sept 30th) and 8 am-8pm 7 days a week (Oct 1st - Mar 31st) (Member Services is closed on the following Holidays: Memorial Day, Independence Day, Thanksgiving and Christmas).
3. Requests for reimbursement may be made by the member; the member's prescribing physician or provider, or the member's representative. If someone other than the member is requesting this reimbursement, please include a completed Appointment of Representative form or equivalent notice with your request.
4. Please submit a separate form for each patient for whom you are submitting receipts.

First Name	Last Name	MI
Telephone Number ( )	Date of Birth	Gender (Circle One) Male Female
ID Number	Subscriber's Employer (PCN)	
Mailing Address		
City	State	ZIP Code
Member Signature		Date Signed

Part 2: Pharmacy Information

1. Complete ALL information.
2. Please submit a separate form for each pharmacy from which you purchased medications.

Name		
Street Address		
City	State	ZIP Code
Pharmacy/or Provider of Service National Provider Number (NA if not available)		Telephone Number ( )

Part 3: Receipt Information

1. Include Proof of Payment with the original pharmacy receipt(s) or pharmacy printout(s). Cash Register Receipt(s) without pharmacy detail will not be accepted. Tape all receipt(s) to the bottom of this page. Please DO NOT staple.
2. Please provide the explanation of benefits (EOB) or denial letter from the primary insurance carrier if you have primary coverage with another insurance carrier.
3. Receipts will not be returned. Please remember to keep a copy of the completed claim form and receipt(s) for your records.

Part 4: Drug Information: *This information should be listed in your original pharmacy receipt, pharmacy printout, or Medical Invoice. If the receipt or invoice is missing any of this information, please ask your pharmacist/or Medical Provider to help fill in the missing details. If you are unable to obtain the information we will attempt to contact your pharmacy.*

Date Rx Filled	Diagnosis Code and Description	Medication Name
Rx Number	National Drug Code	
Day Supply	Quantity	
	Total Volume (grams, ml, each, etc.)	

Prescriber First/Last Name		Prescriber NPI
Original Cost of Rx	Amount Primary Insurance Paid on Rx	Member Paid Amount

Mail this form along with receipts to:

Align Senior Care Manual Claims
PO BOX 1039
Appleton, WI 54912-1039

Or Fax this form along with receipt to:

1-855-668-8550