PRESCRIPTION DRUG REIMBURSEMENT CLAIM FORM INSTRUCTIONS

Please read these instructions carefully before completing this form.

Part 1: Member Information (to be completed by the member/participant)

IMPORTANT NOTE: Payment and related correspondence will be sent to the primary subscriber unless you provide us with an Alternate Address in Part 1.

Part 2: Receipt Information

1. Submit prescription receipts/labels that contain the requested information (shown below) or have your pharmacist complete Part 2 and Part 3. If you do not receive a receipt for your prescription(s), your pharmacist's signature is required.
2. Include all original pharmacy receipt(s). Tape receipts to a separate page to be submitted with the claim form.
   Note: *Please do not staple receipts or other documentation to the claim form.*
3. For multiple claims, please use the multiple prescription forms.

PRESCRIPTION/PHARMACY INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information. ***Please Note:*** *Each pharmacy may have a unique label format.*

Anytime Pharmacy #1234 (509)555-1234
123 Any Street Store NPI: 1234567890
Home Town, US 12345-6789

RX 1234567 Date Filled: 1/1/2009
DOE, JANE DOB: 01/01/1900
456 Home Road (509)555-5678
Home Town, US 12345

Amoxicillin 500 mg capsules (Teva) DAW: 0
00000-1111-22 QTY: 45 Days Supply: 30
A. SMITH, MD NPI: 4567890123
U&C: 200.00 COPAY: 20.00

Please send the completed form and receipt(s) to:

MedImpact Healthcare Systems, Inc.
P.O. Box 509108
San Diego, CA 92150-9108
Fax: 858-549-1569
E-mail: Claims@Medimpact.com