Out-of-Pocket Medication Claim Form

Personal Information

Full Name:

Member ID:

Date of Birth:

Pharmacy Information

Pharmacy Name:

Pharmacy Address:

Medication Information

Medication Name:

Prescription Number:

Date Filled:

Quantity:

Amount Paid ($):

Certification

☐ I certify that the information provided is correct and that the expenses listed have not been reimbursed by any other plan.

Submit Claim