SCRIPT CARE, INC.
DIRECT REIMBURSEMENT FORM
INSTRUCTIONS

When to use this form:

This claim form is to be used only when you purchased a prescription before you received your Script Care identification card, when you purchased a prescription without using your identification card or When you used a non-participation pharmacy. Submit this form as soon as you have your prescription(s) filled in order to receive prompt payment. IT IS NOT necessary to retain the form until you have filled six prescriptions claims.

How to complete this form:

A separate claim form must be completed for each patient.

Complete the Part A of the claim form. Transfer the MEMBER ID number and GROUP number from your identification card. Please be sure to enter the numbers just as they are on the identification card.

Attach the pharmacy receipt with tape to the form.
The receipt **MUST** contain the following information:

- Rx number
- Rx date
- Drug name
- NDC number of the drug dispensed
- Quantity dispensed
- Day supply
- Amount paid.

The **original paid pharmacy receipt(s) must accompany this form. A cash register or charge receipt is not satisfactory, as it does not contain the information noted above. Handwritten receipts are not acceptable.**

If you no longer have original receipts or they do not contain all of the required information, please ask your pharmacy to give you a printout of the claims. Pharmacy printouts are acceptable.

Mail or fax the reimbursement form and all attachments to:

Script Care, Inc.
6380 Folsom
Beaumont, Texas 77706
Fax 409-832-3109

Please allow 6 to 8 weeks for processing and payment of your claim(s). Claim forms submitted without the required information will be returned and/or will cause payment delays.

SCRIPT CARE LTD
6380 Folsom Drive
Beaumont, Texas 77706

Direct Reimbursement Claim Form

IMPORTANT INSTRUCTIONS:

When should you use this form:

1. Between the effective date of the Script Care program and receipt of your ID card.
2. If you are unable to use a participating pharmacy.

Your claim cannot be processed unless this form is complete.

- A separate claim form must be completed for each patient.
- Complete all information requested under Part A.
- Tape prescription receipt(s) to form under Part B - DO NOT STAPLE.
- Use back of form for additional receipt(s).
- Review, sign, and mail completed form with receipt(s) to the address at
- the top of this form.
- Please allow 6 – 10 weeks for payment.

Claims returned for missing information:

Please provide highlighted information and resubmit.

Claim form required	Pharmacy receipt(s)	Patient ID number
Date Dispensed	Prescription Number	Amount Paid
National Drug Code (NDC)	Quantity	Days Supply

Patient not in system, contact your health plan or employer.

Other____

Part A: To be completed by you.

Group Number

Cardmember ID Number

Patient DOB

Patient Gender M F (circle one)

Patient is: Self Spouse Child (circle one)

I certify that the medication(s) described hereon was received by the undersigned for the party(s) named below who is/are eligible for drug benefits, and that such medication(s) is/are not for an on the job injury or covered under another benefit plan. The undersigned authorizes release of all information to any interested party for use in connection with the benefit plan programs. The undersigned further authorizes use of such person's social security number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

Member Name & Address

Member Signature:____________________________Date:___________

Part B: Prescription receipts.

Rx #1

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #2

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #3

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #4

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

SCRIPT CARE LTD

Explanation of Benefits

Your claims have been processed and no payment was made on the following claims for the reason(s) indicated:

Rx date	Rx number	Rejection Code(s)
_________	_____________________	__________________________________
_________	_____________________	__________________________________
_________	_____________________	__________________________________
_________	_____________________	__________________________________
_________	_____________________	__________________________________
_________	_____________________	__________________________________
_________	_____________________	__________________________________
_________	_____________________	__________________________________

1. The claims have been applied toward your deductible.
2. The claim reimbursement is less than your copayment.
3. The medication was refilled too soon, according to the plan design.
4. The claims submitted are for medications that are not covered under your plan.
5. The patient was not covered at the time the claims were incurred.
6. The claims have already been adjudicated by Script Care.
7. Claims older than _____ days/months are not eligible.
8. Your plan does not cover direct reimbursement claims.
9. Your plan allows only a _____ day supply through a retail pharmacy.
10. The claims submitted exceed maximum dispensing limits.
11. Other____

Rx #5

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #6

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #7

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #8

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy