

COORDINATION OF BENEFITS REIMBURSEMENT FORM



Use this claim form to seek reimbursement for prescriptions obtained without the use of your pharmacy benefit plan. Reimbursement is based on your plan's maximum benefit. For questions, call the phone number listed on your ID card or 1-800-207-2568. **Only one patient per form.**

Group Name: Nasomah/Healthcomp RxGrp # (from ID card): 2176

MEMBER INFORMATION

Name: _____ ID# (from ID card): _____
 Address: _____ Apt/Suite: _____
 City: _____ State: _____ Zip: _____

PATIENT INFORMATION

I am the member (may leave name and relationship blank)

Name: _____ Relationship to Member: Spouse (02) Dependent (03)

Birth Date (MM/DD/YYYY): _____ Reason for Reimbursement: _____

Type of Claim	
<p>1. I am seeking reimbursement for a prescription obtained...</p> <p><input type="checkbox"/> without the use of my Pharmacy Benefit Plan. (skip to bottom)</p> <p><input type="checkbox"/> using another primary prescription insurance benefit. (cont. to #2)</p> <p>2. Under my other Primary Prescription Insurance, I have a(n)...</p> <p><input type="checkbox"/> ID card* <input type="checkbox"/> benefit through a medical insurance plan**</p>	<p>* - A copy of your primary prescription insurance ID card.</p> <p>- The original primary insurance prescription receipt showing the copayment amount you paid.</p> <p>** - A copy of the Explanation of Benefits showing your prescription out-of-pocket amount paid.</p> <p>- The original prescription receipt showing the amount you paid at the pharmacy.</p>

Pharmacy/Prescription Information			
Drug Name	Total Quantity	Days Supply	Amount Paid
			\$
Pharmacy NCPDP #: <i>(if unknown, contact the pharmacy)</i>	NDC #: <i>(if unknown, contact the pharmacy)**</i>		
NPI #: <i>(if unknown, contact the pharmacy)</i>			
Drug Name	Total Quantity	Days Supply	Amount Paid
			\$
Pharmacy NCPDP #: <i>(if unknown, contact the pharmacy)</i>	NDC #: <i>(if unknown, contact the pharmacy)**</i>		
NPI #: <i>(if unknown, contact the pharmacy)</i>			
Drug Name	Total Quantity	Days Supply	Amount Paid
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NPI #: <i>(if unknown, contact the pharmacy)</i>			

****If request is for a compound prescription please provide the NDC number for the most expensive drug**

I certify the prescription(s) referred to above have been received and information stated is accurate. I also authorize the release of all information contained herein to Catalyst Rx and its agents. I understand that all prescription receipts must be submitted in order to be processed and considered for reimbursement.

Member Signature: _____ Date: _____

MAIL THIS CLAIM FORM, ALONG WITH BOTH THE PRESCRIPTION AND CASH REGISTER RECEIPT TO:

Catalyst Rx · PO Box 141239 · Irving, TX 75014-1239