Drexi
An AMPS Company

Pharmacy Benefits
Member Reimbursement Form

Member Reimbursement Form Instructions

This claim form can be used to request reimbursement of covered expenses when you have purchased a plan covered prescription drug at retail cost. All reimbursements are subject to limitations and other provisions of the Plan Benefit design for your employer and may be reduced from the submitted amounts based on plan cost and copayments. Any reimbursement due will be refunded to the policyholder.

- Complete ALL information. Your Cardholder Insurance information is located on you member ID card.
- Please submit a separate form for each patient for which you purchased medications.
- Sign the form in the blue Member Signature section in the upper right side of the form
- Without the required information, we cannot process your request.
- For any questions, contact us at (844) 728-3479 or Drexi_customerservice@amps.com

CARDHOLDER INSURANCE

Cardholder Last Name		*Cardholder First Name*		*Middle Initial*	
Rx Group		*ID Number*		*SFX*	
Plan Name				*State*	
Employer Name		*Social Security #*			

PATIENT

Last Name		*First Name*		*MI*	
Date of Birth (MM/DD/YY)		*Relationship to Cardholder*		*Gender*	
Mailing Address			*Phone*		
City		*State*		*Zip*	

Mail To: Drexi Inc.
2700 N. Central Ave, Ste
1110 Phoenix, Arizona 85004

or Email to:
Drexi_customerservice@amps.com

or Secure Fax to:
877.679.1801

FOR OFFICIAL USE ONLY
(Document Control Number)

MEMBER SIGNATURE

I certify that the patient for whom this claim is made is a covered person in this prescription benefits plan and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsored policy holder, and/or employer.

Member Signature		***Date***	

PHARMACY

Pharmacy Name		Phone			
Address					
City		State		Zip	

PRESCRIBER

Prescribing Physicians Name		*Phone*	
Physician/ Practice Address			

REQUEST REASON

- ☐ *I Did Not Have My ID Card at Time of Purchase*
- ☐ *Urgent/Emergency Medication*
- ☐ *Vacation Supply*
- ☐ *Claim Was Rejected at Pharmacy*
- ☐ *Primary Coverage with Another Insurance Carrier (complete COB section below)*
- ☐ *Out-of-Network Pharmacy*
- ☐ *Other:*_____

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If your primary insurance has already paid for any portion of the attached prescription, please complete this section

OTHER INSURANCE PAID AMOUNT	*Other Insurance Name*	*Card Member ID*	*Cardmember Name (Last, First, MI)*	*Amount Primary Insurance Paid*	INSURANCE 2	*Other Insurance Name*	*Card Member ID*	*Cardmember Name (Last, First, MI)*	*Amount Secondary Insurance Paid*

TAPE APPLICABLE RECEIPTS HERE. PLEASE DO NOT STAPLE.

Please submit this form with the original prescription label receipt(s) from the pharmacy. NOTE: Cash register and credit card receipts alone are not acceptable as proof of purchase. Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied. Physician receipt must have those items listed with an asterisk or reimbursement could be delayed or denied.

- Pharmacy Name
- Drug name*, strength, and quantity*
- Prescribing physician's name*
- Prescription number
- Date filled*
- Member paid amount*

If this information is not available, please have the pharmacist complete and sign this form and attach proof of payment.

If receipt is not available, please have your pharmacist complete and sign the following section

PRESCRIPTIONS		*Rx #*	*Medication Name*	*Diagnosis Code & Description*	*Date Written*	*Service Date*	*NDC Number*	*Physician DEA/NPI #*	*Qty Dispensed*	*Days Supply*	DAW	*Patient Paid Amount*
	1											
	2											
	3											
	4											
	5											

PHARMACIST AUTHORIZATION				
Last Name		*First Name*		Pharmacy NABP/NPI #
Pharmacist Signature			***Date***	

I certify that all information regarding the prescription(s), prescriber, pharmacy, and pharmacist are accurate and that the prescription was delivered to the patient on the specified dates, for the specified amounts and quantities.