Prescription Claim Reimbursement Form

For claim reimbursement, complete and mail this form to Phoenix Benefits Management. Mailing Address: 410 Peachtree Parkway Building 400 Ste 4225 , Cumming, GA 30041. Forms can also be faxed to (678) 208-6255. **Incomplete forms will delay processing.** Phoenix Benefits Management Customer help desk can be reached at (888) 532-3299.

**To be completed by Insured. Please PRINT clearly.

I. Member Information		**II. Prescription Plan Information**	
Member Name:		Insured's Member ID #:	
Address:		Group#:	
Birth Date: ___/___/_____	Phone:	Employer:	

III. Patient Information

Relationship to insured:

☐ Self ☐ Spouse ☐ Dependent ☐ Other_____

Is the patient covered by any other medical benefit plan, group policy repayment plan, Medicare, or other government plans?

☐ Yes ☐ No

If Yes, give the name of the person carrying coverage:_____

If Yes, name of the alternate coverage (group name, employer, association, etc):_____

Patient illness or injury (if injury, include a description of the accident, including date and place.)

Did condition result from employment? ☐ Yes ☐ No

If Yes, date your last work prior to treatment for which claim was made:___/___/____

IV. Prescription Information

This section must be completed by you or your dispensing pharmacist. One prescription label should be attached for each prescription. Alternately, include a copy of your pharmacy receipt with this form.

Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled: __/__/___ Quantity:	
RXName & Strenght:		Days Supply:	
NDC #:	DAW:	Price:	Comments:
Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled: __/__/___ Quantity:	
RXName & Strenght:		Days Supply:	
NDC #:	DAW:	Price:	Comments:

Please sign and date here: I certify that the above information is correct and the prescription listed above are for myself or eligible members of my family who have received the medication described above, and I authorize release of all information contained on this claim form to Phoenix Benefits Management and my plan sponsor.

Signature:_____ Date:_____