



Prescription Benefit Managers

Prescription Drug Claim Form

PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM



Use this claim form to request reimbursement for prescription drugs purchased:

- ⇒ Between the effective date of your prescription coverage and the receipt of your card.
- ⇒ When prescription drugs are purchased at a non-participating pharmacy.
(Note: Only if allowed by your plan)



When filling out claim form (reverse side):

- ⇒ Complete a separate form for each family member for whom prescription drugs were purchased.
- ⇒ Complete the top portion of the form in full. Incomplete forms will be returned to you.
- ⇒ Attach a copy of your prescription receipt to the Prescription Drug Claim Form.
- ⇒ Include these numbers from your prescription card:
 - Cardholder's (insured) social security number.
 - 4-digit Carrier/Plan Code.
 - Person Code: Three-digit number assigned to individual family member.



When form is complete:

(Please do not send forms until you receive your prescription card).

- ⇒ Fold with address on outside and affix postage.
- ⇒ **ALL INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION.**

If you have any questions, please call RESTAT's Customer Service at 1-800-248-1062.

FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

FROM:

**AFFIX
POSTAGE**

**RESTAT
PATIENT REIMBURSEMENT
P.O. BOX 758
WEST BEND, WISCONSIN 53095-0758**

- Pharmacy Name and Address
- Prescription Number
- Drug Name
- Drug Cost
- Patient Name
- Fill Date
- Quantity & Days supply

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.