



DIRECT MEMBER REIMBURSEMENT FORM

IMPORTANT: SEE INSTRUCTIONS ON REVERSE SIDE
ORIGINAL RECEIPTS REQUIRED FOR PAYMENT

CARDHOLDER INFORMATION

1. CARDHOLDER NAME (LAST) 2. NAME (FIRST) 3. (MI) 4. DATE OF BIRTH (MM/DD/YYYY)

5. CARDHOLDER RX ID NUMBER 6. OTHER INSURANCE COMPANY (IF ANY)

7. CARDHOLDER STREET ADDRESS 8. DAYTIME PHONE NUMBER

9. CITY 10. STATE 11. ZIP CODE

PATIENT INFORMATION

12. PATIENT NAME (LAST) 13. NAME (FIRST) 14. (MI) 15. MALE 16. FEMALE

17. DATE OF BIRTH (MM/DD/YYYY) 18. SPOUSE 19. CHILD 20. FULL-TIME STUDENT? YES NO

PAYEE INFORMATION (if different than above)

21. PAYEE NAME (LAST) 22. PAYEE NAME (FIRST)

24. PAYEE STREET ADDRESS 23. DAYTIME PHONE NUMBER

25. CITY 26. STATE 27. ZIP CODE

Important: I certify that the patient information on this form is correct, and that the named patient is eligible for the benefits claimed and has received the medication described. I also certify that the medication received is not treatment for on-the-job injury. I authorize NMHCrx to release all information pertaining to this claim to the plan administrator, underwriter, sponsored policy holder and/or the employer, including HIV-related information, mental health treatment information, and/or alcohol/substance abuse treatment information, if any. I understand that payment of this claim will be made to the cardholder unless otherwise specified within this document. I also certify that I have personally incurred this expense and am entitled to reimbursement.

28. PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE
(SIGNATURE REQUIRED FOR REIMBURSEMENT)

PHARMACIST TO COMPLETE THIS SECTION (if not accompanied by receipt)

29. PRESCRIPTION NUMBER 30. DATE RX FILLED (MM/DD/YY) 31. QUANTITY 32. PRESCRIBER ID NUMBER

33. DRUG NAME, STRENGTH, & FORM 34. DAYS SUPPLY

35. COMPOUND 36. NATIONAL DRUG CODE (N.D.C.) 37. \$ TOTAL AMOUNT PAID \$.

38. PHARMACY NAME, ADDRESS, & PHONE NUMBER 39. NABP/NCPDP

40. PHARMACIST SIGNATURE

INSTRUCTIONS

Please read carefully before completing this form. Payment will be delayed unless all information is completed by the cardholder and/or pharmacist.

WHEN SHOULD THESE FORMS BE USED?

Whenever your insurance card is unavailable, or is not accepted by a participating pharmacy, or other situations, where you are due reimbursement from your plan administrator.

CARDHOLDER/PATIENT INFORMATION

Complete all cardholder and patient information on front top portion of the form. (1-20)

You must complete a separate form for each family member.

PAYEE INFORMATION

Payee address information. (21-27)

PAYEE SIGNATURE REQUIRED

Read and sign Certificate Statement covering the prescriptions you have received. (28)

Obtain additional claim forms from MVP (888-687-6277 or www.mvphealthcare.com) or NMHCRX (www.nmhcrx.com), and mail directly to the address below.

PHARMACIST

Complete bottom portion of form. (29-40)

Include prescription number, drug name, strength, and form. (29 & 33)

Indicate date filled, quantity and prescriber ID number. (30-32)

If this is a compounded prescription, enter an "X" in the space provided. (35)

Enter the National Drug Code (NDC) number of the drug/item dispensed. If this is a compounded prescription enter the NDC number of the most expensive legend ingredient. (36)

Indicate dollar amount paid by the patient. (37)

Imprint or stamp with the pharmacy name, address, and phone number. (38)

Enter the complete NABP/NCPDP pharmacy identification number. (39)

Sign bottom of form. (40)

PLEASE ENCLOSE (DO NOT STAPLE) RECEIPT(S), OR EXPLANATION OF BENEFITS FROM YOUR PRIMARY PAYER AND MAIL AS INSTRUCTED BY YOUR PLAN ADMINISTRATOR.

Dear Member,

Enclosed is your reimbursement form for future use. We encourage you to take advantage of the prescription benefit card rather than paying for prescriptions out of your pocket and then waiting for reimbursement from NMHCRX. If you do not have your card, you have the option of having your pharmacist call NMHCRX at 1-800-227-7269 to verify your membership and have your claims paid. If your pharmacy does not participate in our network, please have your pharmacist contact us to become a participating provider.

When traveling, remember to bring your NMHCRX prescription card that is accepted at more than 44,000 participating pharmacies across the United States. If you need help in finding a pharmacy that accepts the card, please call NMHCRX at 1-800-227-7269 for the nearest participating pharmacy.

If you need to use the direct reimbursement method, the following reminders should prevent delays in receiving payment:

- **Always** provide the cardholder's *identification* number, even if the patient is not the cardholder (usually the social security number).
- **Always** include the *correct address* for check mailing.
- **Always** include a *daytime phone number*
- **Always** include your *original pharmacy receipts* (cash register receipts **will not** be accepted).
- **Always** include the drug's *NDC number* (check with the pharmacist)
- **DO NOT** use this form for claims other than medications.

*****PLEASE REMEMBER TO SIGN CLAIM FORM*****

Mail completed forms to:

NMHCRX
ATTN: Reimbursement
P.O. Box 1170
Port Washington, NY 11050

***Any questions may be directed to our Customer Service Department at 1-800-227-7269