DIRECT MEMBER REIMBURSEMENT DIRECTION FORM

Thank you for participating in the Catalyst Rx prescription benefit program. If you are requesting reimbursement on a prescription claim, please take a moment to read the following information for an accurate and timely reimbursement. If you are requesting medical, vision, or dental reimbursement, please contact your benefits office at your place of employment.

- ✓ Complete the top portion of the attached reimbursement form including your name, employee's social security number, mailing address, and group. (employer/school)
- ✓ Use the detailed pharmacy receipt to complete the table at the bottom of the form.
- ✓ Attach the detailed pharmacy receipt. This includes medication dispensed, quantity, and cost.
- ✓ If you do not have the detailed pharmacy receipt, ask your pharmacist to complete and sign the form. Then attach your proof of payment.
- ✓ After you have completed the form and attached proof of payment, please send this information to the address listed on the bottom of the form or you may fax the information to Catalyst Rx at (888) 341-8583.
- ⇒ If Catalyst Rx is your secondary coverage and you are requesting Coordination of Benefits, please call Catalyst RX to confirm that your plan is set up to coordinate benefits.
- ⇒ If the amount you paid is your co-pay, it is not necessary to send in claims for reimbursement. The co-pay is the responsibility of the member and will not be reimbursed. (some exceptions may apply)
- ⇒ Please allow 2 to 6 weeks for your reimbursement check to arrive.

Please remember to present your Catalyst Rx ID card each time you have a prescription filled. If you have any questions regarding your Direct Member Reimbursement Claim or need to know participating pharmacies in your area, please contact our customer service department at (800) 997-3784.

Thank you.
Catalyst RX

2/2/2007

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Please attach a detailed receipt from the pharmacy, including all of the following information. If this information is not on the receipt, please have the pharmacist complete and sign this form and attach proof of payment. **Without the required information CatalystRX will not be able to process your claim.**

PRESCRIPTION FILLED FOR:
EMPLOYEE'S IDENTIFICATION NUMBER (Printed on prescription card):
MAILING ADDRESS:
EMPLOYER NAME:

RX #	Pharmacies NABP #	Fill Date	Drug Name	NDC Number	Prescribing Physician/DEA #	Quantity	Days Supply	Amount Paid

PHARMACIST SIGNATURE: _____ **Pharmacy Phone Number** _____
PHARMACIST SIGNATURE IS REQUIRED WHEN A DETAILED RECEIPT IS NOT PROVIDED.

All reimbursements are subject to plan terms and conditions and may be reduced from the submitted amounts based on plan cost and co-payments.

Please check one of the following reimbursement request reasons:

- ☐ Member did not have the CatalystRX prescription drug card with them.
- ☐ Member did not receive the CatalystRX prescription drug card before the time of purchase.
- ☐ Vacation supply
- ☐ Claim was rejected at the pharmacy.
- ☐ Claim consideration for C.O.B. (secondary coverage)
- ☐ Out of network purchase.
- ☐ Other; Please attach a detailed explanation to be considered for reimbursement.

Fax to:
888-341-8583

Mail to:
Catalyst Rx
Direct Member Reimbursement
PO Box 1069
Rockville, MD 20849-1069