



USE THIS FORM TO REQUEST REIMBURSEMENT FOR CLAIMS THAT YOUR PHARMACY DIDN'T PROCESS UNDER YOUR INSURANCE.

Patient Information	
Cardholder Name: _____	Cardholder ID: _____
Patient Name: _____	Patient DOB: _____
Is this a Coordination of Benefits Claim? Yes No	

Attach additional forms if you have more than 2 medications.

Internal Use Only: Episode Number

Please include a pharmacy receipt for each medication to avoid denial and/or delays in processing your case. A cash register receipt alone cannot be used to process your claims.

All information in the below boxes must be completed in order to avoid delay or denial of your claim.

Medication #1		Medication #2	
Pharmacy NABP: (Obtain from pharmacy)		Pharmacy NABP: (Obtain from pharmacy)	
Fill Date:		Fill Date:	
RX #:		RX #:	
National Drug Code (NDC) (11 Digits)		National Drug Code (NDC) (11 Digits)	
Medication Name:		Medication Name:	
Medication Strength:		Medication Strength:	
Physician Name:		Physician Name:	
Physician NPI: (Obtain from physician)		Physician NPI: (Obtain from physician)	
Quantity/Days Supply:		Quantity/Days Supply:	
Patient Paid:		Patient Paid:	

INTERNAL USE ONLY

Claim Paid:		Claim Paid:	
Claim Denied:		Claim Denied:	
EOC:		EOC:	

Please provide a brief explanation regarding why you paid out of pocket for your medication(s).
(Attach a separate sheet if additional space is required)

This form can be faxed to: 330-888-6015	OR	This form can be mailed to: EnvisionRxOptions Attn: DMR Department 2181 East Aurora Road Suite 201 Twinsburg, OH 44087
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All information in the below boxes must be completed in order to avoid delay or denial of your claim.

Additional Medication		Additional Medication	
Pharmacy NABP: (Obtain from pharmacy)		Pharmacy NABP: (Obtain from pharmacy)	
Fill Date:		Fill Date:	
RX #:		RX #:	
National Drug Code (NDC) (11 Digits)		National Drug Code (NDC) (11 Digits)	
Medication Name:		Medication Name:	
Medication Strength:		Medication Strength:	
Physician Name:		Physician Name:	
Physician NPI: (Obtain from physician)		Physician NPI: (Obtain from physician)	
Quantity/Days Supply:		Quantity/Days Supply:	
Patient Paid:		Patient Paid:	

INTERNAL USE ONLY

Claim Paid:		Claim Paid:	
Claim Denied:		Claim Denied:	
EOC:		EOC:	

Additional Medication		Additional Medication	
Pharmacy NABP: (Obtain from pharmacy)		Pharmacy NABP: (Obtain from pharmacy)	
Fill Date:		Fill Date:	
RX #:		RX #:	
National Drug Code (NDC) (11 Digits)		National Drug Code (NDC) (11 Digits)	
Medication Name:		Medication Name:	
Medication Strength:		Medication Strength:	
Physician Name:		Physician Name:	
Physician NPI: (Obtain from physician)		Physician NPI: (Obtain from physician)	
Quantity/Days Supply:		Quantity/Days Supply:	
Patient Paid:		Patient Paid:	

INTERNAL USE ONLY

Claim Paid:		Claim Paid:	
Claim Denied:		Claim Denied:	
EOC:		EOC:	