



DIRECT MEMBER REIMBURSEMENT FORM

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 Catalyst Rx will not be able to process your claim.**

PRESCRIPTION FILLED FOR (Patient Name):	DATE OF BIRTH (Patient DOB):
PLAN PARTICIPANT IDENTIFICATION NUMBER (Printed on prescription card):	
MAILING ADDRESS:	
PLAN NAME (Employer or Group Name):	

RX #	Pharmacy NABP/NPI #	Fill Date	Drug Name <i>(including strength)</i>	NDC Number	Physician DEA/NPI #	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 copayments. Any reimbursement due will be refunded to the policy holder.

Please check one of the following reimbursement request reasons:

- Member did not have the Catalyst Rx prescription drug card with them.
- Member did not receive the Catalyst R x prescription drug card before the time of purchase.
- Vacation supply
- Claim was rejected at the pharmacy.
- Claim consideration for Coordination of Benefits (secondary coverage).
- Out of network purchase.
- Other; Please attach a detailed explanation to be considered for reimbursement.

Fax to:
1-888-341-8583

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



Dear Plan Participant,

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 for further assistance.

- ✓ Complete the top portion of the attached reimbursement form including the patient's name, plan participant identification number, mailing address, and plan name (employer/group).
- ✓ Use the detailed pharmacy receipt to complete the table in the middle 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 1-888-341-8583. Please retain a copy of the reimbursement request for your records.
- ❖ If Catalyst Rx is your secondary coverage and you are requesting Coordination of Benefits, please call Catalyst Rx Customer Service to confirm that your plan will coordinate benefits.
- ❖ If the amount you paid is your copayment, it is not necessary to send in claims for reimbursement. The copayment 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. If the prescription claim is for a dependent (spouse/child/other), the reimbursement check will be addressed to the policy holder.

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 1-800-997-3784.

Thank you,
Catalyst Rx