University of Michigan Prescription Drug Claim Form

This claim will not be processed until this form and accompanying receipts are submitted.

INSTRUCTIONS FOR COMPLETING PRESCRIPTION DRUG CLAIM FORM

1. Complete all sections of the claim form below.
2. For compound reimbursement requests, submit a completed Universal Compound Form in addition to this form.
3. Include copies of pharmacy receipts and register receipts. The pharmacy receipts must show the following prescription information for each expense:
   - Pharmacy Name and Address
   - Prescription Number and Fill Date
   - Drug Name, Strength, and NDC
   - Drug Cost
   - Patient's Name
   - Prescriber Name
   - Quantity and Days' Supply
   - Amount Paid Out-of-Pocket
4. Mail or fax the completed form and accompanying receipts to:

   Prime Therapeutics , Attn: CP – 4102, P.O. Box 64811, St. Paul, MN 55164-0811

   Fax: 1-866-291-3732

   Note: Reimbursement for medications purchased outside of the United States or at non-network pharmacies are limited to the lesser of your purchase price or the domestic out-of-network prices for the same products, and are based on the exchange rate at the time of the purchase. For more information please visit https://hr.umich.edu/benefitswellness/health-well-being/prescription-drug-plan/coverage-drug-information.
5. Call Customer Service at **1-888-272-1346** if you have any questions.

POLICYHOLDER AND PATIENT INFORMATION

Policyholder or Insured's Name *(First, Middle, Last):* ______________________

Address: ______________________

City: ______________________ State: ______ Zip Code: ______________

Policyholder or Insured's ID No. *(as shown on ID Card)*: ______________________

Why was the insurance or drug card not used for this purchase? ______________________

Patient's Name *(First, Middle, Last)*: ______________________

Patient's Date of Birth: ______________________ Patient's Gender: ☐ Male ☐ Female

Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

OTHER INSURANCE INFORMATION

Is the patient eligible for any other Prescription Drug Coverage? ☐ Yes ☐ No

If ***YES***, does the coverage include: ☐ Major Medical ☐ Drug ☐ Other Medical

Insured's Name: ______________________

Insured's Date of Birth: ______________________

Insured's ID Number: ______________________ Effective Date: ______________________

Insurance Company Name: ______________________

Insurance Address: ______________________

City: ______________________ State: ______ Zip Code: ______________

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to University of Michigan powered by Prime Therapeutics, its agents, or representatives.

Signature: ______________________ **Date:** ______________

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