Print Reset

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. **Please note that reimbursement requests for past purchases must be submitted within 90 days of the service date.**
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
   - 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/benefits-wellness/health-well-being/prescription-drug-plan/pharmacies-claims.
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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