Drug Reimbursement Claim Form

Instructions

Please complete all sections of the Drug Reimbursement Claim Form (DRCF) and attach the prescription receipt(s) for the medications dispensed. Acceptable prescription receipts include:

1. Pharmacy medication claim printout or
2. Individual pharmacy receipts that include the medication name, dosage form, strength and quantity of medication prescribed, prescription number and medication cost.

Insured (Subscriber) Information

Subscriber name: ____
First MI Last

Subscriber Address: ____
Street City State Zip

Subscriber Phone Number: ____
Day Evening E-mail Address

Subscriber Member Number: ____

Patient Information

Patient Name: ____
First MI Last

Patient Member Number: ____

Patient Date of Birth: ____/____/________ Gender (circle one): Male Female

Relationship to Subscriber (circle one): Self Spouse Child Other

Please provide a brief explanation for the submission of claims:

If you submit claims for Coordination of Benefits (COB), please provide the following information:

1. Pharmacy receipts/printout that identifies copays paid and
2. Explanation of Benefits from primary insurer.

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim to Physicians Plus Pharmacy Services for 90 days.

Signature: ____ **Date:** ___/___/___

Send completed information to:
Physicians Plus Pharmacy Services
P.O. Box 2078, Madison, WI 53701-2078
Or FAX completed information to: (608) 327-0324

Note: Please allow 30 days for claim processing. We will contact you via phone or letter if additional information is needed to complete your request. Please contact us at (608) 260-7803 or (800) 545-5015.