FAIRXOS
CLARITY. REDEFINED.

PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medication purchased at retail cost. Complete one form per member, per prescription. This request will be reviewed based off your plan's standard limitations and does not guarantee payment. **Please print clearly and complete all information.**

1 Member Information

First Name	Last Name	MI
Telephone Number	Date of Birth	Gender ☐ Male ☐ Female
ID Number (see ID card)	RxGroup (see ID card)	Prescription is for: ☐ Self ☐ Spouse ☐ Dependent
Mailing Address		
City	State	ZIP code

2 Pharmacy Information

Name		
Street Address		
City	State	ZIP code
Pharmacy National Provider Number (NPI)		Telephone Number

3 Reason for Request

Please select the appropriate option for your request:

☐ I did not use my Prescription Drug ID card
☐ I used a non-participating pharmacy (*please explain)* _____
☐ Primary coverage is with another insurance carrier (Coordination of Benefits)
☐ I was waiting on drug approval
☐ Prescription was filled outside the U.S.
☐ Other *(please explain)* _____

4 Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature:	**Date:**

Instructions for Submitting Form

1. Complete ALL information. Submit claims within the filing period specified by your Benefit plan. For questions please call FairosRx at 1-833-464-9600.
2. Include the **original** pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in the section below.
3. Read the Acknowledgement. Then sign and date.
4. Send completed form with pharmacy receipts to:

FairosRx
1800 S. Washington, Suite 100
Amarillo, TX 79102

Pharmacy receipts for reimbursments

1. Include original pharmacy receipt(s) or pharmacy printout(s). Cash and credit receipts/register receipts are not proof of purchase. Tape original pharmacy receipt(s) to bottom of page. *PLEASE DO NOT STAPLE.*
2. Receipt(s) must contain the information below. If your receipt(s) are missing any of this information, have your pharmacist fill in the missing information in the table below.
3. Please provide the explanation of benefits (EOB) or denial letter from the primary insurance if you have primary coverage with another insurance and you are submitting a coordination of benefits reimbursement request.
4. An incomplete form may be denied, delayed or returned.
5. Receipt(s) will not be returned, remember to keep a copy of the completed claim form and receipt(s) for your records.
6. If the prescription is a compound, please include all drug information in the compound section.

PRESCRIPTIONS: (A new form is needed for each prescription)

Rx Written Date	Date Rx Filled	Medication Name
Rx Number	National Drug Code (NDC)	
Day Supply	Quantity	
Prescribing Physician First/Last Name		Prescribing Physician NPI
Original Cost of Rx	Amount Primary Insurance Paid on Rx	Member Paid Amount

COMPOUND PRESCRIPTIONS:

NDC Number	Drug Ingredient	Quantity	Charge

Fraud Prevention Regulation: Any person who knowingly and intentionally defraud any health plan or other party files an application for insurance or statement of claim containing any false material or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent health plan act, which is a crime and subjects such person to criminal and civil penalties.