restat
a Catamaran company

catamaran

Prescription Drug Claim Form

Use this claim form to request reimbursement for prescription drugs purchased:

- Between the effective date of your prescription coverage and the receipt of your card.
- When prescription drugs are purchased at a non-participating pharmacy.
  (Note: Only if allowed by your plan)

When filling out claim form (reverse side):

- Complete a separate form for each family member for whom prescription drugs were purchased.
- Complete the top portion of the form in full. Incomplete forms will be returned to you.
- Attach a copy of your prescription receipt to the Prescription Drug Claim Form.
- Include these numbers from your prescription card:
  - Cardholder's (insured) Identification (ID) Number.
  - 4-digit Carrier/Plan/Group Code.
  - Person Code: Three-digit number assigned to individual family member.

When form is complete:

(Please do not send forms until you receive your prescription card).

- Fold with address on outside and affix postage.
- **ALL INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION.**

If you have any questions, please call Restat's Customer Service at 1-800-248-1062.

Customer Service Hours of Operation: M-F 7AM-1AM CST; SAT & SUN 8AM-5PM CST

FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

FROM:

_____
_____
_____

AFFIX POSTAGE

Restat, a Catamaran Company
Patient Reimbursement
11900 W. Lake Park Drive
Milwaukee, WI 53224

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a Catamaran company

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Please read REVERSE SIDE before completing this form. (PLEASE PRINT)

Cardholder Name:_____
First Middle Last

Cardholder ID Number: _____ **4-digit Carrier / Plan / Group Code:** _____

Cardholder Address: _____
Street

_____
City State Zip

Employer Name:_____ **Insurance Company:**_____

Patient Name:_____
First Middle Last

Person Code_____ **Patient's Date of Birth**____ /____ /____ **Patient Sex: M F (Circle One)**

If your medication is covered under ANY OTHER Insurance Plan, provide the name of the Employer and Insurance Company:

_____

_____

Note: If the Primary Insurance Company does not pay a pharmacy benefit, an Explanation of Benefits from the Primary Insurance Company OR a print-out from the pharmacy explaining the reason for non-payment should be submitted with this claim form.

I certify that the above information is correct and that the person is eligible for benefits. I have received the medication described below and authorize release of all information contained on this voucher to Restat and the underwriter.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

CARDHOLDER SIGNATURE: _____

To receive reimbursement:

Attach copies of prescription receipts showing the following information:

- Pharmacy Name and Address
- Prescription Number
- Drug Name and Strength
- Drug Cost
- Patient Name
- Fill Date
- Quantity & Days supply
- Amount Paid

Your claim cannot be processed unless this form is complete.