

**MEMBER REIMBURSEMENT DRUG CLAIM FORM**  
**UFCW & EMPLOYERS BENEFIT TRUST (UEBT)**



Please mail this claim form directly to:  
**informedRx Manual Claims**  
**P.O. Box 3299**  
**Lisle, IL 60532-8299**

For assistance please call:  
**( 8 6 6 ) 6 3 5 - 6 9 0 6**  
 24 hours a day, 7 days a week

**Please print or type this information**

RxGrp#	<input type="text"/>	I.D. # (SSN)	<input type="text"/>
<small>(See ID Card for number)</small>			
Plan/Employer Name: ( <b>REQUIRED</b> )			
Cardholder's Last Name		First Name:	Middle Initial
Cardholder's Street Address:		City:	State: Zip:
(    ) <input type="text"/> - <input type="text"/>		(    ) <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>
Cardholder's Day Time Phone Number:		Cardholder's Evening Phone Number:	
<input type="text"/>		<input type="text"/>	
Patient's Name: (Use a separate claim form for each covered family member)		Patient's Date of Birth	
<input type="checkbox"/> Female <input type="checkbox"/> Male <small>Patient Gender</small>		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <small>Patient's relationship to cardholder</small>	

**CHECK REASON FOR SUBMISSION (if applicable)**

*Reasons checked must apply to all prescriptions. If submitting prescription label receipts for different reasons, please use a separate form.*

- Reimbursement of co-payments (other prescription insurance, dual coverage or COB)
- Eligibility issue that could not be resolved through Fund Office at time of receiving the prescription
- Depo Provera when dispensed by Kaiser for administration at a Kaiser facility
- Compound Medication
- Special Distributors (not related to Specialty drugs.) This exception is for certain medications such as Xolair, Nexvar, Exjade, and Kuvan which can only be purchased through certain distributors.
- No UEBT Network Pharmacy within 10 miles of home or work. Please provide your work address below.  
 Work Address: \_\_\_\_\_
- Emergency (please explain) \_\_\_\_\_

**CLAIM WILL BE RETURNED IF REQUIRED INFORMATION IS MISSING**

Date: \_\_\_\_\_ Employee's Signature \_\_\_\_\_

I certify that all information on this claim form is accurate. I understand that informedRx, Inc.'s use or disclosure of individually identifiable health information, whether furnished by me or obtained from another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

**MEMBER REIMBURSEMENT DRUG CLAIM FORM (CONTINUED)**

RxGrp#	<input type="text"/>	I.D. # (SSN)	<input type="text"/>
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(See ID Card for number)

**WITHOUT PHARMACIST SIGNATURE - PHARMACY LABEL RECEIPTS ARE REQUIRED**

Date: \_\_\_\_\_ Pharmacist's Signature \_\_\_\_\_

<b>1</b>	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay		Pharmacy Address & Phone Number		
<input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx				

<b>2</b>	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay		Pharmacy Address & Phone Number		
<input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx				

<b>3</b>	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay		Pharmacy Address & Phone Number		
<input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx				

<b>4</b>	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay		Pharmacy Address & Phone Number		
<input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx				

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Cash register receipts are not accepted. Please make copies for your records - documents will NOT be returned.

**Questions? Call ( 8 6 6 ) 6 3 5 - 6 9 0 6**