

Member Prescription Reimbursement Claim Form

Use this claim form to seek reimbursement for prescriptions obtained at a non-participating pharmacy.

MEMBER SECTION Please submit one form for each individual patient.

Co./Plan name: _____ Group Number: _____
 Member Name: _____ Soc. Sec. Number: _____ - _____ - _____
 Member Address: _____
 City: _____ St: _____ Zip: _____ - _____
 Patient Name: _____ (if other than member)
 Relationship: ___ 02=spouse ___ 03=dependent (if other than member)
 Birth Date: _____ - _____ - _____ Sex: ___ Male ___ Female
 Patient ID: _____ (11 digit ID - copy exactly from WHI ID card)
 Request Reason (i.e. traveling, etc.): _____

PHARMACY SECTION Incomplete information may delay processing or may cause form to be returned.
 (If you need assistance in filling out necessary information, please refer to your receipt or contact the pharmacy in which the medication was dispensed.)

Pharmacy NABP (7 digits)	Rx #	Fill Date	Total Paid	Qty	Days Supply	Drug NDC# 11 digits	Prescriber Name	DAW Code

I certify the prescription(s) referred to above have been received and information stated is accurate. I also authorize the release of all information contained herein to Walgreens Health Initiatives and its agents.
 Participant's Signature: _____ Date: _____

Mail to:
Walgreens Health Initiatives
P.O. Box 545
Deerfield, Illinois 60015

Don't forget to attach the original prescription receipt and the cash register receipt to this form.
 Reimbursement is based on your Plan's maximum benefit.
 Questions concerning this form, call 1-800-207-2568