WithMe Health
Direct Member Reimbursement Form

Patient Information

Member ID:	Date of Birth (mm/dd/yyyy):
Patient Name (First, Last):	Patient's Relationship to Primary Subscriber: ❑ Self ❑ Spouse ❑ Dependent
Address: (Street, City, State, ZIP)	
I certify that the information submitted in this form is correct and that the patient indicated above is eligible for benefits. _____ Patient/Subscriber/Member or Legal Representative Signature	

Pharmacy Information

Pharmacy Name:
Pharmacy Address: (Street, City, State, ZIP)

Prescription Claim Information

Please attach original pharmacy receipts to space provided on the form. If receipts are not included, please have the pharmacist complete and sign the bottom of this form.
Was this prescription medication purchased outside the U.S.A.? ❑ Yes ❑ No

Please note:

Processing and payment of your Direct Member Reimbursement request is subject to the terms and conditions of your Group's Benefit Plan contract.

All fields below must be completed (example on the next page) Call your pharmacist if you need assistance.		
1	Rx Number:	Date Filled:
	Quantity:	Day Supply:
	Name of Medication:	National Drug Code (NDC): (Your pharmacist can provide)
	Physician NPI Number:	Prescription Cost:
	Amount Paid (if any):	
2	Rx Number:	Date Filled:
	Quantity:	Day Supply:
	Name of Medication:	National Drug Code (NDC): (Your pharmacist can provide)
	Physician NPI Number:	Prescription Cost:
	Amount Paid (if any):	
3	Rx Number:	Date Filled:
	Quantity:	Day Supply:
	Name of Medication:	National Drug Code (NDC): (Your pharmacist can provide)
	Physician NPI Number:	Prescription Cost:
	Amount Paid (if any):	

Pharmacy/Prescription Information

1. Use a separate claim form for each patient.
2. Attach pharmacy receipts in the spaces provided. Be sure that each receipt is readable.
   Each receipt must show: • Patient Name • Quantity • Pharmacy Name/Address • Fill Date • Total Charge • Rx Number • Drug Name and NDC Number • Days' Supply
   If any of your receipts do not have required information, ask your pharmacist to provide you with the missing information. Write that information on your receipt(s). If not completed, the claim will be sent back for the required information.
3. You or your pharmacist can call WithMe Health at 1-866-840-1877 if you have any questions.
4. Send completed form and receipt(s) via mail to:

WithMe Health Member Reimbursements
204 E 2ND AVE # 337
San Mateo, CA 94401

Or send the completed form and receipt(s) via fax to fax number: 1-866-834-4614

Example of how to complete the Prescription Drug Claim Form:

1	Rx Number: 00000123456	Date Filled: 01/01/2020
	Quantity: 30	Day Supply: 30
	Name of Medication: Lisinopril	National Drug Code (NDC): 00591-0405-01 (Your pharmacist can provide)
	Physician NPI Number: 1111222333	Prescription Cost: $5.80
	Amount Paid (if any): $5.80	

Is this prescription claim for a compound medication? ❑ Yes ❑ No
Note: If yes, make sure your pharmacist completes the information below.

Compound Information:
If this is a compound prescription, please enter all information per drug used.

Compound Prescriptions:
For pharmacy use only.

NDC Number	Drug Ingredient	Quantity	Charge

Pharmacy Receipts Only: Add one pharmacy receipt in this space

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