Explanation of Benefits (EOB) Request Form

To request an EOB, complete this form and return to CastiaRx. It's fast and easy to go online and print your own EOB using our secure member portal – visit **CastiaRx.com/members** and click ***Member Portal***.

1. Provide background information

PATIENT NAME

DATE OF BIRTH

MEMBER ID

EMPLOYER OR PLAN SPONSOR

PHONE NUMBER

ADDRESS

CITY

STATE

ZIP

2. Provide EOB information

Identify the EOB period for which you are requesting records

FROM: MONTH YEAR

TO: MONTH YEAR

Identify where the EOB should be mailed

☐ Same address as above

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY

STATE

ZIP

Questions? Call **866.516.3121** or visit **CastiaRx.com**

Form continues on back >

3. Check your work and authorize

1. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.
2. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

   CastiaRx, Attn: Compliance Officer, 13660 California Street, Omaha, NE 68154
3. I understand that I can view the CastiaRx Notice of Privacy Policy at CastiaRx.com and have the right to receive a paper copy upon request. To obtain a paper copy, contact CastiaRx at 866.516.3121
4. A copy of this authorization is as valid as the original.

PATIENT SIGNATURE* (or patient's personal representative) DATE

*All dependents age 18 and over must sign this form. Information will not be released for a dependent aged 18 and over who does not sign this form.

If signed by a patient's personal representative, please complete the following and attach supporting documentation:

☐ Power of Attorney ☐ Guardianship ☐ Court Order ☐ Other

RELATIONSHIP TO PATIENT AUTHORITY TO ACT FOR THE PATIENT

4. Submit this form

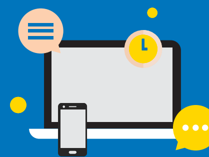
Request forms may be submitted by:

Email: MemberServices@CastiaRx.com // Fax: 866.632.7946

Mail: CastiaRx, Attn: Member Services, 13660 California Street, Omaha, NE 68154

Please allow 2-4 weeks for the request to be processed.

Questions? Contact Member Services 24 hours a day, 7 days a week.
Call 866.516.3121



Ditch the paperwork and switch to digital! View your prescription information on our member portal.