Member Reimbursement Claim Form

To request reimbursement for covered medications purchased at retail cost, complete this form and submit it to CastiaRx with the pharmacy receipt. A separate claim form must be completed for each patient.

1. Provide background information

Cardholder Information

FIRST NAME | LAST NAME | M.I. | DATE OF BIRTH

MEMBER ID | EMPLOYER OR PLAN SPONSOR

☐ Primary insurance
☐ Secondary insurance

ADDRESS | CITY

STATE | ZIP | EMAIL | PHONE NUMBER

Patient Information

☐ Same as cardholder

FIRST NAME | LAST NAME | M.I. | DATE OF BIRTH

2. Provide prescription information

Provide pharmacy and drug information for prescriptions for which you are requesting reimbursement. The pharmacy receipt with prescription details must be included for each prescription. **This is not a cash register receipt – see page 2 for example**. If you do not have the receipt, you must include an explanation of benefits (EOB) provided by the pharmacy.

Prescription One

PHARMACY NAME | PHARMACY ADDRESS

DRUG NAME & STRENGTH | QUANTITY | DAY SUPPLY

RX NUMBER | DATE FILLED | $ PRICE

Prescription Two

PHARMACY NAME | PHARMACY ADDRESS

DRUG NAME & STRENGTH | QUANTITY | DAY SUPPLY

RX NUMBER | DATE FILLED | $ PRICE

Prescription Three

PHARMACY NAME | PHARMACY ADDRESS

DRUG NAME & STRENGTH | QUANTITY | DAY SUPPLY

RX NUMBER | DATE FILLED | $ PRICE

3. Check your work and authorize

I certify that the information is correct and that the prescription(s) listed above are for myself or eligible dependents. I have received the medication(s) above and authorize release of all information contained on this claim to CastiaRx and/or my plan sponsor.

CARDHOLDER SIGNATURE | DATE

4. Submit this form

Reimbursement claim form and pharmacy receipts may be submitted by:

Email: DMR@CastiaRx.com

Fax: 314.652.3126

Mail: CastiaRx
Attn: Member Reimbursement
701 Emerson Road, Suite 301
Creve Coeur, MO 63141

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

Pharmacy Receipt Example:

Pharmacy Name
Pharmacy Address and Phone
Date Filled

Patient Name
Patient Address

Rx #0000000000
Medication Name NDC #
Quantity Day Supply $X.XX