Member Reimbursement Claim Form

CastiaRx Medicare Part D Members

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. Background information

Patient Information

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

GROUP NUMBER _____ MEMBER ID _____

☐ Primary insurance
☐ Secondary insurance

ADDRESS _____ CITY _____

STATE _____ ZIP _____ EMAIL _____ PHONE NUMBER _____

2. Prescription information

Provide pharmacy and drug information for prescriptions for which you are requesting reimbursement. The original 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.

Pharmacy Name	**Drug Name & Strength**	**Rx Number**

Questions?
Call **800-546-5677** // TTY **866-706-4757**
Visit **CastiaRx.com**

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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.

SIGNATURE

DATE

4. Submit this form

Reimbursement claim form and pharmacy receipts may be submitted by:

Fax: 866-632-7946

Mail: CastiaRx
Attn: Member Reimbursement
PO Box 407
Boys Town, NE 68010

Please allow up to 2 weeks for the request to be processed.

Pharmacy Receipt Example:

Pharmacy Name — Date Filled
Pharmacy Address and Phone

Patient Name
Patient Address

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

ATTENTION: CastiaRx complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. If you speak another language, language assistance services, free of charge, are available to you. Call 800-546-5677 (TTY: 866-706-4757).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-546-5677 (TTY: 866-706-4757). // CastiaRx cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-546-5677（TTY：866-706-4757）。 // CastiaRx 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。