Prescription Drug Claim Reimbursement Form

Please read REVERSE SIDE before completing this form: YOUR CLAIM CANNOT BE PROCESSED IF THIS FORM IS INCOMPLETE.

Plan Member Name _____
First Middle Last

Patient Name _____
First Middle Last

_____ _____ _____ Patient's Date of Birth ☐☐ ☐☐ ☐☐☐☐ Patient: Sex M F (Circle One)
Plan Member ID Number Patient Code Group Number
mm dd yyyy

Plan Member Address _____
Street City State Zip

_____ _____
Employer Name Insurance Company

I certify that the above information is correct and that the above checked person is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this voucher to VytlOne and the underwriter.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

_____
Plan Member Signature

Is this medication covered under any other group insurance plan? YES _____ NO _____ If YES: WHO? _____

Please ask your pharmacist to complete the remaining portion: YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE
You must attach a copy of the prescription receipts.

Rx Number:	**Rx Number:**	**Rx Number:**
Date Filled:	**Date Filled:**	**Date Filled:**
Quantity:	**Quantity:**	**Quantity:**
Days Supply:	**Days Supply:**	**Days Supply:**
Rx Price:	**Rx Price:**	**Rx Price:**
Medication Name:	**Medication Name:**	**Medication Name:**
Dosage Form:	**Dosage Form:**	**Dosage Form:**
Strength:	**Strength:**	**Strength:**
NDC No.:	**NDC No.:**	**NDC No.:**
Doctor's DEA #:	**Doctor's DEA #:**	**Doctor's DEA #:**
Doctor's Name:	**Doctor's Name:**	**Doctor's Name:**

REASON FOR MANUAL CLAIM: _____

PLACE PHARMACY LABEL HERE OR ENTER:

_____ _____
Pharmacy Name Area Code - Phone Number

_____ _____
Street Address NABP#

_____ _____
City State Zip Pharmacist Signature

Prescription Drug Claim Reimbursement Form

Please Read Carefully Before Completing This Form

Use this claim form to request reimbursement for prescription drugs purchased:

* In emergency situations when a non-participating pharmacy is utilized.

When filling out claim forms:

* Complete a separate form for each family member for whom prescription drugs were purchased.
* Complete a separate form for each pharmacy where prescription drugs were purchased.
* Complete the top portion of the form in full. Incomplete forms will be returned to you for completion.
* Include these numbers from your prescription card:
  - Plan member's (insured) ID number
  - Patient code: two-digit number assigned to individual family member (listed on card)
* Attach a copy of your prescription receipt to the lower portion OR give to your pharmacist to complete.

Please return completed form and prescription receipts:

* By Mail:
  - VytlOne
    Patient Reimbursement Claims
    320 S. Polk, Suite 200
    Amarillo, TX 79101
* Online:
  - Scan the completed form and receipts and send securely through the live chat feature within the Member Portal at www.VytlOneMembers.com

If you have any questions, please contact VytlOne Member Services at (800) 687-0707.