***Prescription Drug Claim Form** for*
Direct Member Reimbursement

Group Health Cooperative
of South Central Wisconsin

Use this claim form to request reimbursement of covered expenses. Please check which reason applies.

- ☐ My primary coverage is with another insurance carrier (include copy of EOB or denial letter).
- ☐ I did not present my ID card at the time of purchase.
- ☐ I used a non-participating pharmacy (specify why).

Other:

INSTRUCTIONS: Please complete a separate form for each prescription. Include both the detailed pharmacy receipt AND to the proof-of-payment/cash register receipt. Submissions will not be returned, please keep a copy for your records. The pharmacy can provide you with the NPI numbers requested to identify the pharmacy and physician. NOTE: Use of a non-participating pharmacy may result in reimbursement of the usual approved cost, which may be less than you were charged.

PART ONE- MEMBER INFO

First Name	Last Name
GHC member #	**Signature/Date**

PART TWO- PHARMACY INFO (pharmacy name & address, or NPI number, if not legible on receipt)

Name	Address
City	State/Zip
Pharmacy NPI #	

PART THREE- PRESCRIPTION INFO (Information legible on the receipt does not need to be written in)

Date filled	Drug name
Rx Number	NDC #
Quantity	Days Supply
Physician name	Physician NPI #
Rx price	If applicable, amount Paid by primary insurance
	Diagnosis:

Mail the completed form and receipts to:
GHC-SCW Pharmacy Admin
P.O. Box 44971
Madison, WI 53744-4971

Or
Fax the completed form and receipts to:
GHC-SCW Pharmacy Admin
(608) 828-4810