

## Drug Reimbursement Claim Form

### Instructions

Please complete all sections of the Drug Reimbursement Claim Form (DRCF) and attach the prescription receipt(s) for the medications dispensed. Acceptable prescription receipts include:

1. Pharmacy medication claim printout or
2. Individual pharmacy receipts that include the medication name, dosage form, strength and quantity of medication prescribed, prescription number and medication cost.

### Insured (Subscriber) Information

Subscriber name: \_\_\_\_\_

First

MI

Last

Subscriber Address: \_\_\_\_\_

Street

City

State

Zip

Subscriber Phone Number: \_\_\_\_\_

Day

Evening

E-mail Address

Subscriber Member Number: \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_

First

MI

Last

Patient Member Number: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender (circle one): Male Female

Relationship to Subscriber (circle one): Self Spouse Child Other

### Please provide a brief explanation for the submission of claims:

If you submit claims for Coordination of Benefits (COB), please provide the following information:

1. Pharmacy receipts/printout that identifies copays paid and
2. Explanation of Benefits from primary insurer.

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim to Physicians Plus Pharmacy Services for 90 days.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Send completed information to:  
Physicians Plus Pharmacy Services  
22 E Mifflin, Suite 200  
Madison, WI 53701  
OR  
FAX completed information to:  
(608) 258-1905

Note: Please allow 30 days for claim processing. We will contact you via phone or letter if additional information is needed to complete your request. Please contact us at (608) 260-7803 or (800) 545-5015, ext. 7803.