MEMBER REIMBURSEMENT DRUG CLAIM FORM

Complete this form, attach prescription labels and fax or mail to:

Evidence-Based Prescription Drug Program (EBRx)
4301 W. Markham St., Slot #522
Little Rock, AR 72205
Fax: (501) 526-4189

Cardholder Information

Cardholder's ID Number:	Group / Employer Name and Number:
Cardholder's Name (Last, First, Middle):	Cardholder's Birthdate: (MM/DD/YYYY)
Cardholder's Address: (Street, City, State, Zip):	Cardholder's Telephone Number: ( )

Patient Information

Prescription(s) were for:

Patient Name: (First, Middle, Last)	Gender: ☐ Male ☐ Female	Employee ☐ Spouse ☐ Dependent ☐	Patient Birthdate: (MM/DD/YYYY)

Reason for Request

☐ Coordination of benefits with primary pharmacy or medical plan
☐ Compound claim
☐ Out of area / urgent / emergency request
☐ Eligibility issue at the pharmacy
☐ Other, please describe:

Pharmacy Information

Pharmacy Name:	Pharmacy NABP Number:
Pharmacy Address: (Street, City, State, Zip):	
Pharmacy Telephone Number: ( )	Pharmacist Signature: Date:

Prescription Information

Please include the prescription labels with this form (receipts are not acceptable) or a pharmacy printout signed by the pharmacist. You can ask your pharmacist for assistance in completing the information below. Completing this entire form will result in timely processing of your claim. **For questions concerning this claim please call EBRx at (833) 339-8401.**

Date Filled:	Rx Number:	Rx (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code (11 digits) | | | | | | | | | | |
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA# / Rx Price Paid
Date Filled:	Rx Number:	Rx (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code (11 digits) | | | | | | | | | | |
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA# / Rx Price Paid
Date Filled:	Rx Number:	Rx (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code (11 digits) | | | | | | | | | | |
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA# / Rx Price Paid

I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Signature:	Date: