catamaran™

DIRECT MEMBER REIMBURSEMENT FORM

Please attach a detailed receipt from the pharmacy, including all of the following information. If this information is not on the receipt, please have the pharmacist complete and sign this form and attach proof of payment. **Without the required information, Catamaran will not be able to process your claim.**

PRESCRIPTION FILLED FOR (Patient Name):	**DATE OF BIRTH (Patient DOB):**
PLAN PARTICIPANT IDENTIFICATION NUMBER (Printed on prescription card):	
MAILING ADDRESS:	
PLAN NAME (Employer or Group Name):	

Rx #	Pharmacy NABP/NPI #	Fill Date	Drug Name *(including strength)*	NDC Number	Physician DEA/NPI #	Quantity	Days Supply	Amount Paid

PHARMACIST SIGNATURE:_____ **PHARMACY PHONE NUMBER:** _____

**PHARMACIST SIGNATURE IS REQUIRED WHEN A DETAILED RECEIPT IS NOT PROVIDED.*

All reimbursements are subject to plan terms and conditions and may be reduced from the submitted amounts based on plan cost and copayments. Any reimbursement due will be refunded to the policyholder.

Please check one of the following reimbursement request reasons:

- ☐ Member did not have the Catamaran prescription drug card with them
- ☐ Member did not receive the Catamaran prescription drug card before the time of purchase
- ☐ Vacation supply
- ☐ Claim was rejected at the pharmacy
- ☐ Claim consideration for Coordination of Benefits (secondary coverage)
- ☐ Out-of-network purchase
- ☐ Other; please attach a detailed explanation to be considered for reimbursement

Fax to:
1-888-341-8583

Mail to:
Catamaran
Direct Member Reimbursement
P.O. Box 1069
Rockville, MD 20849-1069

Any person who knowingly and willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.