Prescription Drug Program
Member Direct Reimbursement Form

Complete and return this form when you have purchased a covered prescription drug at retail cost and are seeking reimbursement. *Limit = one (1) form per individual.* Submit this form with original prescription receipt/label to expedite processing. *A cash register receipt alone is not acceptable as proof-of-purchase.* [Compound medications require all NDC (NATIONAL DRUG CODE) numbers, ingredients, and quantities used for each ingredient. Pharmacies may fill out a universal claim form to provide detailed information.] **Please allow up to six (6) weeks for processing.**

General Information [ONE FORM PER PATIENT]

Employer Name [PLEASE PRINT]	Group Number	Employee ID
Name of Employee *[Last Name, First Name, Middle Initial]*	Date of Birth	Age
Mailing Address *(Number, Street, City, State, Zip Code)*	Phone Number(s)	
Name of Prescription Holder [IF DIFFERENT FROM THE EMPLOYEE]	Date of Birth	Age
Mailing Address [IF DIFFERENT FROM THE EMPLOYEE]	Phone Number	
Prescribing Physician's Name	Physician's Phone Number(s)	

Reason for Request [AT LEAST ONE (1) MUST BE CHECKED.]

- ☐ Emergency medication filled out of area
- ☐ Non-urgent medication *OR* vacation request
- ☐ No identification card or identification number available
- ☐ Eligible member with invalid group
- ☐ Referral of non-contracted physician
- ☐ Compound medication
- ☐ Non-contracted pharmacy
- ☐ Other _____

Certification/Authorization/Signature [THIS CLAIM WILL BE RETURNED IF THE MEMBER (OR SUBSCRIBER) SIGNATURE IS NOT PRESENT.]

I certify that the patient for whom this claim is made is a person covered under an American Health Care prescription drug program and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or workers' compensation insurance program. I authorize release of all information pertaining to the enclosed claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

X_____ _____
Member (or Subscriber) Signature — Date

All payments and correspondence will be issued to the primary member or subscriber.

Special Instructions [PRESCRIPTION RECEIPT/LABEL MUST HAVE THE FOLLOWING INFORMATION CLEARLY LEGIBLE OR PAYMENT CAN BE DELAYED OR DENIED.]

* Drug Name, Strength, and Quantity
* Prescription Number and Date
* Prescribing Physician's Name
* Pharmacy Name
* Member Expense
* [for compounds] NDC#s and Quantities used for each ingredient

Please mail your receipt(s)/label(s) and this completed form to:

American Health Care
Attn: Member Direct Reimbursements
2217 Plaza Drive
Rocklin, CA 95765