224 North Park Ave • Fremont, NE 68025
Phone: (800) 228-3108 • Fax: (888) 810-1394

# Reimbursement Request Form

*Note: Please send to the attention of the "Reimbursement Department" when mailing this form to Sav-Rx.*

## Participant Information

| | | |
|---|---|---|
| **Cardholder Name** (See ID Card): | | |
| **Cardholder ID** (See ID Card): | **Relation to Cardholder**: ☐ **Self** ☐ **Dependent** | |
| **Participant Name**: | **Date of Birth**: | |
| **Phone Number**: | **Email Address**: | |
| **Address**: | | |
| **City**: | **State**: | **Zip Code**: |

## Prescription Information

| | |
|---|---|
| **Number of Prescriptions Submitted**: | **Date Prescription(s) Filled**: |
| | *(For multiple prescriptions please use a range from first to last)* |
| **Out-of-Pocket Total**: | **Coupon Used At Time Of Processing**: ☐ Yes ☐ No |

## Reimbursement Information

In the space below, please provide the reason for not utilizing the Sav-Rx card/ submitting this reimbursement request:

**Please provide receipts for prescriptions along with this form.**

*Please note any receipts submitted to Sav-Rx for reimbursement must include the following*

- Member Name
- Date of Service
- Drug Name
- Quantity Dispensed
- Amount Patient Paid
- Drug NDC
- Prescription Number

Cardholder Signature

Date

By signing the above, you attest that all information is true to the best of your abilities in seeking reimbursement for medications paid out of pocket and/ or that did not adhere to the benefit structure – resulting in a larger amount paid. You also acknowledge that there is no guarantee of reimbursement for medications that may have required a prior authorization or clinical review prior to dispensing the medication(s).