DIRECT MEMBER REIMBURSEMENT FORM

INSTRUCTIONS: Complete the information requested below and attach a copy of the receipt(s). If the requested information is not provided on the receipt, have your pharmacist complete the information requested and provide proof of payment. NOTE: REIMBURSEMENT WILL BE PROVIDED AT THE PLAN'S REIMBURSEMENT RATE MINUS THE REQUIRED CO-PAYMENT. Copies of this form may be made for additional drugs.

Primary Cardholder Information

Cardholder Name:____
Last Name First Name Middle Initial

Cardholder Identification #: ________________________ Group /Rx Plan #:_____________

Employer or Plan Name: ____

Patient Information and Certification

Patient Name:____
Last Name First Name Middle Initial

Certification: I certify that I, or my participating dependent, received the medicine(s) documented below. I further certify that I am, or my participating dependent is, an eligible participant in the pharmacy program designated above. The medicines received are not for treatment of a job related injury or covered under another pharmacy plan. I hereby authorize release of all pertinent information to Scriptsense and authorized representatives necessary to process my claim including my employer. I certify that all information provided on or with this form is accurate.

Signature of Plan Participant:____
Date:

Rx Number	Pharmacy # (NABP #)	Drug Name	Drug NDC #	Date Rx Filled	Quantity	Days Supply	Price

Your Mailing Address:

____

____

____
City State Zip Code

Mail To: Scriptsense, Inc.
3349 Executive Parkway, Suite I
Toledo, Ohio 43606

REMEMBER TO INCLUDE YOUR RECEIPTS!