CAPSL
Pharmacy Benefits Administrator

Prescription Reimbursement

How to Use This Form

Use this form to request prescription reimbursement for eligible prescriptions claims that you paid for out of pocket or out of network.

To ensure faster processing of your claim, be sure to do the following:

- Complete the form on your computer or print it out and complete it using black or blue ink and print clearly and legibly.
- Complete all the applicable fields on the form.
- You may only use one form per claim.

If you have other insurance or Medicare, and it is primary to your plan, please include the explanation of benefits (EOB) from your other insurance or Medicare.

To Receive the Maximum Benefit

Use a participating pharmacy to receive the maximum benefit. Your pharmacist can provide you with the most cost-effective options for your prescription.

For prescriptions that require prior authorization or notification, be sure to call the Member Services number on the back of your ID card.

What Happens Next

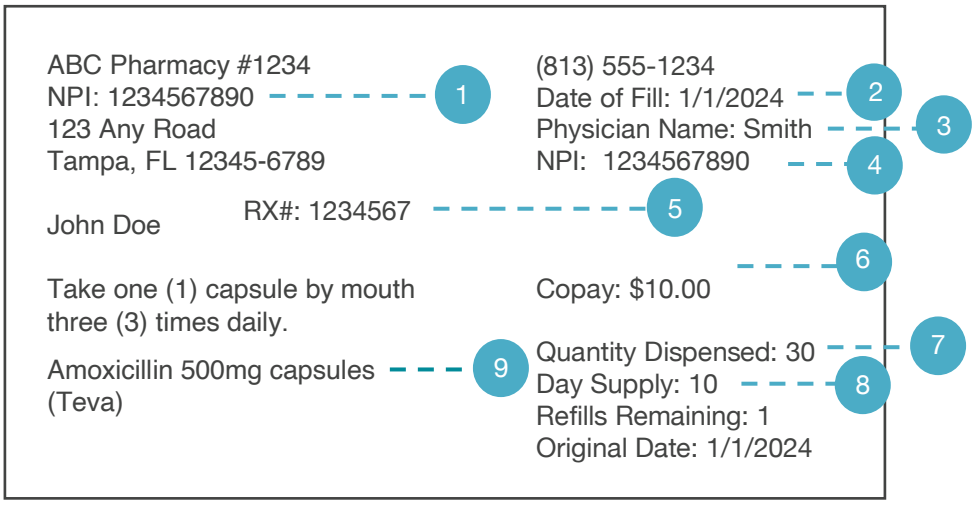
Complete and print the form. Attach a copy of your receipt. Mail to:

ATTN: RxSense DMR Team
3001 PGA Boulevard, Suite 202
Palm Beach Gardens, FL 33410

Your request will be processed, and a response provided in approximately 4-6 weeks.

Below is a sample prescription label. Use this as a guide to find the information you need to complete this form. Each pharmacy has its own label format.

Please ask your pharmacy to obtain any missing information.



1. Pharmacy NPI (National Provider Identification)
2. Date of Fill
3. Physician Name
4. Physician NPI Number
5. Prescription (RX) Number
6. Amount Paid
7. Quantity Dispensed
8. Day Supply
9. Drug Name
10. NDC (National Drug Code for the drug filled)

Prescription Reimbursement Form

Member Information			
Patient's Name (Last Name, First Name, MI)		Patient's DOB	Patient's Sex
Patient's Email			Patient's Phone
Insured's Name (Last Name, First Name, MI)		Patient's Relationship to Insured	
ID Number (on the front of your card)	Account/Plan Number (on the front of your card)		

Prescription Information			
Date Filled	RX Number	Quantity Dispensed	Day Supply
Drug Name			Drug Strength
Dosage Type (Optional)	Manufacturer (Optional)		
NDC# (Optional)	Pharmacy Name		
Pharmacy NPI (Optional)	Pharmacy NABP (Optional)		Amount Paid (Receipt Required)
Pharmacy Address			
Prescriber Name (Last Name, First Name)		Prescriber NPI (Optional)	
Prescriber Address (City, State, Zip)			

Acknowledgement		
By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.		
Signature	Date	Phone

Return Address	
IMPORTANT: *Provide current mailing address.* ***(A copy of the receipt must be included)***	
First Name	Last Name
Street Address	City, State, Zip