ENVISIONRx

USE THIS FORM TO REQUEST REIMBURSEMENT FOR CLAIMS THAT YOUR PHARMACY DIDN'T PROCESS UNDER YOUR INSURANCE.

Patient Information

Cardholder Name: _____ Cardholder ID: _____

Patient Name: _____ Patient DOB: _____

Is this a Coordination of Benefits Claim? Yes No

Attach additional forms if you have more than 2 medications.

Internal Use Only: Episode Number

Please include a pharmacy receipt for each medication to avoid denial and/or delays in processing your case. A cash register receipt alone cannot be used to process your claims.

All information in the below boxes must be completed in order to avoid delay or denial of your claim.

Medication #1		Medication #2	
Pharmacy NABP: (Obtain from pharmacy)		Pharmacy NABP: (Obtain from pharmacy)	
Fill Date:		Fill Date:	
RX #:		RX #:	
National Drug Code (NDC) (11 Digits)		National Drug Code (NDC) (11 Digits)	
Medication Name:		Medication Name:	
Medication Strength:		Medication Strength:	
Physician Name:		Physician Name:	
Physician NPI: (Obtain from physician)		Physician NPI: (Obtain from physician)	
Quantity/Days Supply:		Quantity/Days Supply:	
Patient Paid:		Patient Paid:	
INTERNAL USE ONLY			
Claim Paid:		Claim Paid:	
Claim Denied:		Claim Denied:	
EOC:		EOC:	

Please provide a brief explanation regarding why you paid out of pocket for your medication(s).

(Attach a separate sheet if additional space is required)

This form can be faxed to: 330-888-6015 **OR** This form can be mailed to:

EnvisionRxOptions
Attn: DMR Department
2181 East Aurora Road Suite 201
Twinsburg, OH 44087

All information in the below boxes must be completed in order to avoid delay or denial of your claim.

Additional Medication			Additional Medication		
Pharmacy NABP: (Obtain from pharmacy)			Pharmacy NABP: (Obtain from pharmacy)		
Fill Date:			Fill Date:		
RX #:			RX #:		
National Drug Code (NDC) (11 Digits)			National Drug Code (NDC) (11 Digits)		
Medication Name:			Medication Name:		
Medication Strength:			Medication Strength:		
Physician Name:			Physician Name:		
Physician NPI: (Obtain from physician)			Physician NPI: (Obtain from physician)		
Quantity/Days Supply:			Quantity/Days Supply:		
Patient Paid:			Patient Paid:		
INTERNAL USE ONLY					
Claim Paid:			Claim Paid:		
Claim Denied:			Claim Denied:		
EOC:			EOC:		

Additional Medication			Additional Medication		
Pharmacy NABP: (Obtain from pharmacy)			Pharmacy NABP: (Obtain from pharmacy)		
Fill Date:			Fill Date:		
RX #:			RX #:		
National Drug Code (NDC) (11 Digits)			National Drug Code (NDC) (11 Digits)		
Medication Name:			Medication Name:		
Medication Strength:			Medication Strength:		
Physician Name:			Physician Name:		
Physician NPI: (Obtain from physician)			Physician NPI: (Obtain from physician)		
Quantity/Days Supply:			Quantity/Days Supply:		
Patient Paid:			Patient Paid:		
INTERNAL USE ONLY					
Claim Paid:			Claim Paid:		
Claim Denied:			Claim Denied:		
EOC:			EOC:		