CatalystRx®
A HealthExtras® Company

Direct Member Reimbursement Form

Please attach a detailed receipt from the pharmacy that includes all of the information below. If the information below is not included on the receipt, please have the pharmacist complete and sign this form and attach proof of payment. **Without the required information Catalyst Rx will not be able to process your claim.**

PRESCRIPTION FILLED FOR: ______________________________

EMPLOYEE'S IDENTIFICATION NUMBER (Printed on prescription card): ______________________________

MAILING ADDRESS: ______________________________

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EMPLOYER NAME: ______________________________

RX #	Pharmacy's NCPDP #	Fill Date	Drug Name	NDC Number	Prescribing Physician/DEA #	Quantity	Days Supply	Amount Paid

PHARMACIST SIGNATURE: ______________________________ PHARMACY PHONE NUMBER ______________________________

All reimbursements are subject to plan terms and conditions and may be reduced from the submitted amounts based on plan cost and copayments.

Please check one of the following reimbursement request reasons:

- ☐ Member did not have their Catalyst Rx prescription drug card with them
- ☐ Member did not receive their Catalyst Rx prescription drug card before the time of purchase
- ☐ Vacation supply
- ☐ Claim was rejected at the pharmacy
- ☐ Claim consideration for Coordination Of Benefits (secondary coverage)
- ☐ Out-of-network purchase
- ☐ Other; Please attach a detailed explanation to be considered for reimbursement

Fax to: **877-524-3784**

Mail to: **Catalyst Rx**
Direct Member Reimbursement
PO Box 1069
Rockville, MD 20849-1069