



DIRECT REIMBURSEMENT CLAIM FORM

Complete, print and attach receipt. Cash Register Receipts Not Acceptable.

Mail: **NMHC RX**, Attention: Claims Department
P.O. Box 1170
Port Washington, NY 11050

Remember, include your pharmacy receipt and complete BOTH Sections in full. Incomplete claim forms will result in a delay in reimbursement.

MEMBER COMPLETE

GROUP NUMBER	GROUP NAME - DEA		
MEMBER NAME: LAST	FIRST	INITIAL	
MEMBER ID			
STREET ADDRESS			
CITY	STATE	ZIP	
PATIENT NAME: LAST	FIRST		
PATIENT DATE OF BIRTH	SEX:	MALE	FEMALE
RELATIONSHIP TO MEMBER:	MEMBER	SPOUSE	CHILD
I certify that the medication described hereon was received for the personal use of the named patient who is eligible for drug benefits, and authorize the release of information contained hereon or pertaining hereto to the insurance carrier.			
Signature of Patient or Guardian or Legal Representative <input checked="" type="checkbox"/> _____			

PHARMACIST COMPLETE

PHARMACY NAME	PHARMACY NABP#		
PHARMACY STREET ADDRESS			
CITY	STATE	ZIP	
RX NUMBER	TOTAL RX CHARGE \$ _____		
DATE RX FILLED			
NAME OF MEDICATION			
STRENGTH	DOSE	MANUFACTURER	
METRIC QUANTITY	DAYS SUPPLY		
NATIONAL DRUG CODE (11 DIGIT NDC# includes LABELER#, PRODUCT#, & PKG#)			
DIRECTIONS FOR USE			
PRESCRIBING PHYSICIAN			
PHARMACIST SIGNATURE			

To avoid the need for filing a claim for reimbursement in the future, present your **NMHC RX** card at the pharmacy at the time of purchase. **NMHC RX** is accepted at over 97% of pharmacies nationwide