

# DIRECT MEMBER REIMBURSEMENT FORM

(To be used for reimbursement out of network prescriptions)

Mail completed form and receipts to



7227 N 16<sup>th</sup> Street, Suite 160  
Phoenix, AZ 85020

## QualxServ

1. Please type or print clearly. All information in each section must be provided. Incomplete forms will be returned, causing a delay in payment
2. Tape original receipt to the form where indicated below.
3. Ask pharmacy for their NCPDP number.
4. A separate form must be completed for each patient and for each pharmacy patronized
5. The insured person must sign each claim form submitted

### INSURED & PATIENT INFORMATION

Group Name <b>QualxServ</b>	Group Number <b>QUALX</b>		
Insured Name (Last,First,MiddleInitial)	Insured ID Number		
Address	Daytime Phone ( )		
City State Zip	Work Phone ( )		
Patient Name	Sex Male Female	Relationship to Insured Self Spouse Dependent	Date of Birth
Prescriber Name	Prescriber DEA#	Prescriber Phone Number	
<b>I certify the above information is correct to the best of my knowledge. The patient named is eligible for benefits and receive the medication (s) referenced below, and authorize release of all information contained on this form to United Drugs and the underwriter.</b>			
<b>Insured's Signature</b>		<b>Date</b>	
_____		_____	

### PHARMACY INFORMATION

Pharmacy Name	NABP Number	
Address	Phone ( )	
City	State	Zip

### PRESCRIPTION RECEIPTS

Tape prescription receipts # 1 here. If there is not National Drug Code (NDC) number and / or Days Supply on the receipt, please obtain from the pharmacist and enter below.		Tape prescription receipts # 1 here. If there is not National Drug Code (NDC) number and / or Days Supply on the receipt, please obtain from the pharmacist and enter below	
NDC # _____ Days Supply		NDC # _____ Days Supply	
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