



Prescription Drug Claim Reimbursement Form

Please read page 2 before completing this form: YOUR CLAIM CANNOT BE PROCESSED IF THIS FORM IS INCOMPLETE.

Plan Member Name _____
 First _____ Middle _____ Last _____

Patient Name _____
 First _____ Middle _____ Last _____

Plan Member ID Number _____ Patient Code (Optional) _____ Group Number _____
 Patient's Date of Birth

mm	dd	yyyy
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 Patient: Sex M F (Circle One)

Plan Member Address _____
 Street _____ City _____ State _____ Zip _____

Employer Name _____ Insurance Company _____

I certify that the above information is correct and that the above checked person is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this voucher to VytlOne and the underwriter.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

 Plan Member Signature

Is this medication covered under any other group insurance plan? YES _____ NO _____ If YES: WHO? _____

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE
You must attach a copy of the prescription receipts.

Rx Number:	Rx Number:	Rx Number:
Date Filled:	Date Filled:	Date Filled:
Quantity:	Quantity:	Quantity:
Days Supply:	Days Supply:	Days Supply:
Rx Price:	Rx Price:	Rx Price:
Medication Name:	Medication Name:	Medication Name:
Dosage Form:	Dosage Form:	Dosage Form:
Strength:	Strength:	Strength:
NDC No.:	NDC No.:	NDC No.:
Doctor's NPI # (Optional):	Doctor's NPI # (Optional):	Doctor's NPI # (Optional):
Doctor's Name:	Doctor's Name:	Doctor's Name:

REASON FOR MANUAL CLAIM: _____

PLACE PHARMACY LABEL HERE OR ENTER:

Pharmacy Name _____

Area Code - Phone Number _____

Street Address _____

NABP# / NPI# (Optional) _____

City _____ State _____ Zip _____

Pharmacist Signature (Optional) _____

Prescription Drug Claim Reimbursement Form

Please Read Carefully Before Completing This Form

Use this claim form to request reimbursement for prescription drugs purchased out of pocket.

When filling out claim forms:

- * Complete a separate form for each family member for whom prescription drugs were purchased.
- * Complete a separate form for each pharmacy where prescription drugs were purchased.
- * Complete the top portion of the form in full. Incomplete forms will be returned to you for completion.
- * Attach a copy of your prescription receipt OR give to your pharmacist to complete.

Please return completed form and prescription receipts:

- * By Mail:
 - VytIOne
Member Reimbursement Claims
320 S. Polk, Suite 200
Amarillo, TX 79101
- * Online:
 - Log into your Member Portal account at www.members.vytalone.com
 - Use the live chat feature and attach the completed form and receipt image(s) OR
 - Select the Member Reimbursement tile, complete the online form, upload the receipt image(s), and click 'Submit Claim'

If you have any questions, please contact MaxorPlus Member Services at (800) 687-0707.