integrated pharmacy services

REQUEST FOR EXPLANATION OF BENEFITS (EOB)

Note: You can print your own EOB by registering with LDI's secure on-line Pharmacy Benefit Service. If you would like to register, please follow these steps:

1. Go to www.ldirx.com
2. From LDI's home page, click on 'login' located in the center tab labeled 'RxServices for Members'
3. Click on the link labeled 'Click here for new registrations'
4. If you Accept LDI's Consumer Terms and Conditions, please press 'Accept' to continue registration
5. Complete the secure online registration form. You must have your Cardholder ID (located on your member ID card) to register.

Patient Name: _____ **Date of Birth:** ____ / _____ / _____
MM DD YYYY

Street Address: _____

City, State and Zip: _____

Daytime phone: _____

Employer / Plan Sponsor Name: _____

1. Please identify the EOB period for which you are requesting records:

   From: _____ To: _____
   Month Year Month Year

2. Please identify where the EOB should be mailed:

   Name: _____

   Address: _____

   _____

   _____

   _____

   If the EOB is being mailed to someone other than yourself, please state the relationship.

   Relationship to Patient: _____
   (e.g. Accountant, Spouse, Third-Party Insurance, Workers Compensation etc.)

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3. I understand that the health information that I authorized to be disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.

4. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

   LDI Integrated Pharmacy Services
   Attn: LDI Privacy Officer
   701 Emerson Road, Suite 301
   Creve Coeur, MO 63141

5. I understand that I have a right to request and receive a copy of LDI's Notice of Privacy Practices at www.LDIRx.com

6. A photo copy of this authorization is as valid as the original.

Please sign and date below.

SIGNATURE REQUIRED FOR ALL REQUESTS

_____ _____
Signature of patient or patient's personal representative Date

*** Note: All dependents age 18 and over must sign this request form**. Data will not be generated for any dependent aged 18 and over who does not sign this request form.

If signed by patient's personal representative, please complete the following and attach supporting documentation [please check one]:

□ Power of Attorney □ Guardianship □ Court Order □ Other

Relationship to Patient: _____

Authority to Act for the patient: _____

Please return completed form to:

LDI Integrated Pharmacy Services
Attn: LDI Privacy Officer
701 Emerson Road, Suite 301
Creve Coeur, MO 63141
Fax: (314) 652-3126

Please allow 2 - 4 weeks for the request to be processed.
For questions or concerns, please call toll-free (866) 516-2121, ext. 6608