LDI Integrated Pharmacy Services

MEMBER REIMBURSEMENT CLAIM FORM

LDI integrated pharmacy services
Health Solutions Made Personal.

PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS FORM
INCOMPLETE FORMS WILL DELAY PROCESSING OF CLAIM
PHARMACY PRESCRIPTION RECEIPTS MUST ACCOMPANY FORM

CARDHOLDER/INSURED'S NAME:______________________________________
LAST FIRST MI

CARDHOLDER/INSURED'S
ADDRESS:____________________________ CITY/STATE/ZIP _________________________________

PATIENTS DATE OF BIRTH: ____________________ DAYTIME PHONE #_____-______-_______

INSURED'S MEMBER ID: _______________________ GROUP #: ________________________

PLAN SPONSOR/EMPLOYER: ____

PLEASE CIRCLE IF THIS IS YOUR **PRIMARY** OR **SECONDARY** INSURANCE

PRESCRIPTION INFORMATION: THIS SECTION MUST BE COMPLETED BY YOU OR YOUR PHARMACIST.
PLEASE COMPLETE THE PATIENT, PHARMACY AND DRUG INFORMATION FOR EACH PRESCRIPTION FOR REIMBURSEMENT. ***PRESCRIPTION RECEIPT MUST BE ATTACHED, ONE FOR EACH BOX.***

Patient's Name:____________________________	Rx No: ____________________________________
Patient's Person Code:_______	Date Filled: ______________
Pharmacy Name:___________________________	Quantity: ________________
Pharmacy Address:_________________________	Days Supply: _____________
Drug Name & Strength:______________________	Price $: _________________
	Pharmacist Signature, if required:
NDC #:___________________________________	____
Patient's Name:____________________________	Rx No: ____________________________________
Patient's Person Code:_______	Date Filled: ______________
Pharmacy Name:___________________________	Quantity: ________________
Pharmacy Address:_________________________	Days Supply: _____________
Drug Name & Strength:______________________	Price $: _________________
	Pharmacist Signature, if required:
NDC #:___________________________________	____
Patient's Name:____________________________	Rx No: ____________________________________
Patient's Person Code:_______	Date Filled: ______________
Pharmacy Name:___________________________	Quantity: ________________
Pharmacy Address:_________________________	Days Supply: _____________
Drug Name & Strength:______________________	Price $: _________________
	Pharmacist Signature, if required:
NDC #:___________________________________	____

PLEASE SIGN AND DATE HERE

I CERTIFY THAT THE INFORMATION IS CORRECT AND THAT THE PRESCRIPTIONS LISTED ABOVE ARE FOR MYSELF OR MEMBERS OF MY FAMILY WHO ARE ELIGIBLE. I HAVE RECEIVED THE MEDICATION DESCRIBED ABOVE AND AUTHORIZE RELEASE OF ALL INFORMATION CONTAINED ON THIS CLAIM TO LDI INTEGRATED PHARMACY SERVICES AND MY PLAN SPONSOR

_________________________________ _________________________________
CARDHOLDER SIGNATURE DATE SIGNED

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE THE REVERSE SIDE OF THIS FORM. A SEPARATE FORM MUST BE COMPLETED FOR EACH PATIENT.

CARDHOLDER/INSURED INFORMATION: CARDHOLDER/INSURED IS THE PRIMARY PERSON COVERED UNDER THE BENEFIT.

CARDHOLDER/INSURED'S MEMBER ID #: THIS *NUMBER* IS PRINTED ON THE CARD –*Print the number in the boxes by the Cardholder/Insured's Member ID #.*

PERSON CODE: EACH MEMBER COVERED UNDER THIS BENEFIT HAS A PERSON CODE - *Print the Person Code of the Cardholder in the boxes for the Cardholder/Insured's.*

GROUP #: GROUP PRINTED ON THE CARD CONNECTS YOUR NAME TO YOUR BENEFIT – *Print the Group # as shown on your LDI Pharmacy Benefits ID Card.*

CARDHOLDER/INSURED'S NAME – *Write the Last, First, and Middle Initial of the Cardholder/Insured's Name.*

DAYTIME PHONE NUMBER: *Write in the daytime phone number of the Cardholder/Insured*

CARDHOLDER/INSURED'S ADDRESS – *Write in the address of the Cardholder/Insured's Mailing Address.*

PRESCRIPTION INFORMATION: Please write in the information required in the following boxes attaching the receipt describing the prescription, not a cash register receipt. If you do not have the receipt, the required information must be completed and signed by your pharmacist. Claims will not be reimbursed if receipt does not accompany form or the pharmacist does not sign the form.

Complete one box for each prescription. Submit one LDI Reimbursement Form for each patient.

Patient's Name: *Print or Type in the name of the patient for whom the prescription was written.*
Patient's Person Code: *Print or Type in the Person code of the patient for whom the prescription was written. This Person Code is on the ID Card.*
Pharmacy Name: *Print or Type in the Name of the Pharmacy that filled the prescription.*
Pharmacy Address: *Print or Type the Address of the Pharmacy that filled the prescription.*
Drug Name and Strength: *Print or Type in the Drug Name & Strength as shown on the medication package.*
NDC #: *Print or Type in the NDC Code as listed on the prescription medication package or receipt.*
Rx#: *Print or Type the Prescription Number (Rx #) as it appears on the medication package.*
Date Filled: *Print or Type the Date the Prescription was filled.*
Quantity: *Print or Type the amount of medication received.*
Price: *Print or Type the amount you paid for the prescription, less taxes.*
Pharmacist Signature: *Pharmacist dispensing prescription is required to sign if prescription receipts does not accompany reimbursement form.*

CARDHOLDER/INSURED'S RETURN ADDRESS

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PLACE STAMP HERE

TO: LDI integrated pharmacy services
MEMBER REIMBURSEMENT
701 Emerson Road, Suite 301
Creve Coeur, MISSOURI 63141

EXAMPLE OF PHARMACY RECEIPT

PHARMACY NAME
ADDRESS
PHONE NUMBER

RX: XXXXXXXXXX — DATE FILLED
YOUR NAME
YOUR ADDRESS — COST OF MEDICATION

MEDICATION NAME
NDC #:
QUANTITY RECEIVED — DAYS SUPPLY