

## Member Prescription Reimbursement Claim Form

Use this claim form to seek reimbursement for prescriptions obtained at a non-participating pharmacy.

**MEMBER SECTION** Please submit one form for each individual patient.

Client Name: State of Arizona Client Number: 2298  
 Member Name: \_\_\_\_\_ Soc. Sec. Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Member Address: \_\_\_\_\_  
 City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ (if other than member)  
 Relationship: \_\_\_\_ 02=spouse \_\_\_\_ 03=dependent (if other than member)  
 Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex: \_\_\_\_ Male \_\_\_\_ Female  
 Patient ID: \_\_\_\_\_ (9 digit ID - copy exactly from WHI ID card)  
 Request Reason (i.e. traveling, etc.): \_\_\_\_\_

**PHARMACY SECTION** Incomplete information may delay processing or may cause form to be returned.

(If you need assistance in filling out necessary information, please refer to your receipt or contact the pharmacy in which the medication was dispensed.)

Pharmacy NABP (7 digits)	Rx #	Fill Date	Total Paid	Qty	Days Supply	Drug NDC# 11 digits	Prescriber Name	DAW Code

I certify the prescription(s) referred to above have been received and information stated is accurate. I also authorize the release of all information contained herein to Walgreens Health Initiatives and its agents. I understand that all prescription receipts must be submitted within 180 days of prescription receipt date in order to be processed and considered for reimbursement.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mail to:  
**Walgreens Health Initiatives**  
**P.O. Box 691569**  
**Orlando, FL 32819-7819**

*Don't forget to attach the original prescription receipt and the cash register receipt to this form.*  
 Reimbursement is based on your Plan's maximum benefit.  
 Questions concerning this form, call 1-800-207-2568