

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE THE DIRECT MEMBER REIMBURSEMENT FORM

1. Print Group Number and Group Name (found on prescription drug card)
2. Print Insured/Cardholder Name (The cardholder is the insured member whose employer provides the benefit.)
3. Print Cardholder's mailing address
4. Print Claimant/Patient's name (Complete a new form for each family member who is submitting prescriptions.)
5. Print Cardholder's ID number (found on prescription drug card)
6. Identify relationship to cardholder, date of birth, gender, and date the prescription was filled.
7. Copy of the receipt as Proof of Payment.
8. Please Sign.

PLEASE ASK YOUR PHARMACIST TO COMPLETE THE REMAINING PORTION: WE CANNOT PROCESS THIS FORM WITHOUT THIS INFORMATION.

*** PHARMACIST YOU MAY ATTACH UCF TO THIS FORM***

Each submission must include:

- Date Filled
- Rx Number
- Quantity
- Days Supply
- National Drug Code
- Drug name, Strength, Dosage Form
- Medical Doctor Name & DEA Number
- Price
- Pharmacy Name and NABP Number

Please note that Claims received missing any the required information may be returned or payment may be denied.

Signature of Pharmacist or Dispensing M.D. Required

Questions? Call 4-D Pharmacy Management Systems at 1-888-274-2031

Please return this claim to:	4-D Pharmacy Management Systems Direct Member Reimbursement P.O. Box 721098 Berkley, MI 48072
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