

Prescription Drug Claim Form

Cardholder Name:
First Middle Last

Cardholder ID Number: 4-Digit Plan Code:

Cardholder Address:
Street

City State ZIP

Employer Name:

Patient's Name:
First Middle Last

If your medication is covered under ANY OTHER insurance plan, provide the name of the Employer and Insurance Company: _____

Note: If the primary Insurance Company does not pay a pharmacy benefit, an Explanation of Benefits from the Primary Insurance Company or a print-out from the pharmacy explaining the reason for non-payment should be submitted with this claim form.

I certify that the above information is correct and that the person is eligible for benefit. I have received the medication described below and authorize release of all information contained on this voucher to BMR and the underwriter.

I agree that any benefit payable hereunder for prescription drugs is 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.

Cardholder Signature:

Date:

Attach Copies of prescription receipt showing: Pharmacy name, Prescription number, Drug name, Drug cost, Patient name, Fill date and Quantity & Days supply.

Instructions for preparing a Prescription Drug Claim

Use the "BMR Prescription Drug Claim Form" to request reimbursement for prescription drug purchased:

- Between the effective date of your prescription coverage and the receipt of your BMR Drug Card.
- When prescription drugs are purchased at a non-participating pharmacy.

When filling out the BMR claim form:

- Complete a separate form for each family member for whom prescription drugs were purchased.
- Complete the top portion of the form in full.
- Attach a copy of your prescription receipt to the claim form.
- Include these numbers from your BMR Drug Card:
 - Cardholder's Identification Number.
 - 4-digit Plan Code.
 - Person Code: Three-digit number assigned to the individual family member.

When the form is complete:

- Place the form and copy of the receipt in an envelope and affix postage.
- Address to:
**BROADREACH MEDICAL
RESOURCES, INC.
1350 BROADWAY, STE #1901
NEW YORK, NY 10018**
- If you have questions, contact BMR Member Services at 1-866-718-2375 or email memberservices@bmr-inc.com.