Direct Member Reimbursement

At times, you may be required to submit a claim form and your receipts for reimbursement for prescriptions you purchased at a retail pharmacy. This process of reimbursing is called Direct Member Reimbursement, or DMR.

As a member, as long as you use your ID card at an ASCEND participating pharmacy, you are not required to submit your receipts or a claim form for reimbursement. Anytime you pay out of pocket for a prescription that is covered under your plan, you can submit a request for reimbursement.

Eligible prescription drugs purchased and paid in full by an enrollee will be reimbursed at the pharmacy contracted rate minus your co-payment, whichever is less.

To submit a request for reimbursement, complete this form within 90 days after the date the medication was filled.

If you have questions please call Member Services at **833-200-5040.**

INSTRUCTIONS:

Enclose the following

- Copy of the Cardholder ID number and Group number (RxGrp) from your ID card.
- Your Plan Sponsor is your employer or the organization through which you receive benefits
- Be sure to read the release, sign and date this form certifying accuracy of the information provided.
- Retain copies of all documentation as forms and receipts submitted to ASCENDpbm will not be returned.

Be sure you have completed the form accurately and included the following for each prescription to be reimbursed. If you do not have the details or an itemized receipt, your pharmacist can assist you in completing the form and have them sign the front. If you are submitting a compound prescription for reimbursement, have your pharmacist complete and sign the top of this page, even if you do have an itemized receipt.

- Your prescription #
- Date of purchase
- Prescription NDC#
- Name of medicine
- Strength of the prescription
- Day supply
- Quantity
- Prescriber DEA#
- Pharmacy NABP#
- Prescription number
- Total cost for each prescription

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be according to the parameters of your prescription benefit plan and only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

Items not covered under your prescription benefit plan should not be submitted for reimbursement including Durable Medical Equipment. Diabetic supplies requiring a prescription are reimbursable only if covered by your plan. Canceled checks and cash register receipts are not acceptable forms of receipts to be submitted for reimbursement.

CARDHOLDER INFORMATION

Cardholder ID# **RxGrp#** **Plan Sponsor**

Cardholder Name **Phone** **Date of Birth (MM/DD/YYYY)**

Cardholder Address **City** **State** **Zip Code**

MEMBER INFORMATION (if different from cardholder)

Member Name | **Date of Birth (MM/DD/YYYY)**

Relationship to member: ☐ Spouse ☐ Child ☐ Other | **Gender:** ☐ Female ☐ Male

Member Name | **Phone**

Member Address | **City** | **State** | **Zip Code**

SIGNATURE / RELEASE

By signing this form you certify that the information provided is accurate and authorize the release of all necessary information to all appropriate parties involved in the administration of this claim. All medications described herein were received by the named patient and he/she is eligible for benefits. None of the named medications described herein are covered under another benefit plan or for an on-the-job injury.

Signature (Member, Parent or Guardian) | **Print Name** | **Date**

PRESCRIPTION AND PHARMACY INFORMATION

Prescription label example: please use this example as a guide to locate the required information.
Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234
123 Any Street
Home Town, US 12345-6789
10. **Store NPI: 1234567890**
(509) 555-1234

RX 1234567
1. **DOE, JANE**
456 Home Road
Home Town, US 12345

3. **Date Filled:** 1/1/2009
2. **DOB:** 01/01/1900
(509) 555-5678

7. ***Amoxicillin 500 mg capsules (Teva)**
6. ***NDC #00000-1111-22**
DAW: 0
4. ***QTY: 45**
5. ***Days Supply: 30**
8. ***U&C: 200.00**
9. ***COPAY: 20.00**

1. Patient name*
2. Patient date of birth*
3. Date filled*
4. Quantity*
5. Day supply*
6. National drug code (NDC)*
7. Medication name and strength*
8. Usual and customary price (U&C)/RX price*
9. Copay*
10. Pharmacy NPI or NABP number*

***REQUIRED INFORMATION-CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED**

If you don't have original receipts, ask your pharmacist for a copy or have them complete and sign the bottom of this form.

Pharmacist: By signing this form, you certify the information on this form below correctly represents the amount charged and the prescriptions dispensed. You acknowledge that all payments related to these prescriptions will be paid to the member.

Signature (Pharmacist or Pharmacy Representative) | **Print Pharmacist Name** | **Date**

PRESCRIPTION #1: **Pharmacy Name**_____**Phone**_____

Rx Number | **Date Filled** | **NDC#** | **Medicine**

☐ New ☐ DAW
☐ Refill ☐ Compound

Strength | **Day Supply/Dosing** | **Quantity**

Prescribers DEA# | **Pharmacy NABP#** | **Member $ Total Cost**

FOR INTERNAL USE ONLY:

APPROVAL INITIALS AND DATE

PRESCRIPTION #2: **Pharmacy Name**_____ **Phone**_____

Rx Number	Date Filled	NDC#	Medicine
			☐ New ☐ DAW
Strength	**Day Supply/Dosing**	**Quantity**	☐ Refill ☐ Compound
Prescriber's DEA#	**Pharmacy NABP#**	**Member $ Total Cost**	**FOR INTERNAL USE ONLY:** _____ **APPROVAL INITIALS AND DATE**

PRESCRIPTION #3: **Pharmacy Name**_____ **Phone**_____

Rx Number	Date Filled	NDC#	Medicine
			☐ New ☐ DAW
Strength	**Day Supply/Dosing**	**Quantity**	☐ Refill ☐ Compound
Prescriber's DEA#	**Pharmacy NABP#**	**Member $ Total Cost**	**FOR INTERNAL USE ONLY:** _____ **APPROVAL INITIALS AND DATE**

COMPOUNDED PRESCRIPTION MEDICATIONS

To be completed by your pharmacist if the prescriptions being submitted for reimbursement are compound medications, even if you have itemized receipts:

NDC#	INGREDIENT	QUANTITY	COST

Pharmacist or Pharmacy Representative Signature **Printed Name** **Date**

EMAIL COMPLETED FORM TO:
HELPDESK@ASCENDPBM.COM

PLEASE NOTE: Keep in mind that communications via email over the internet are not secure. There is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

MAIL COMPLETED FORM TO:

ASCENDpbm
ATTN: BILLING
6480 Technology Drive,
Suite A 103
Kalamazoo, MI 49009

FAX COMPLETED FORM TO:
877-326-2856

QUESTIONS?

If you have questions, please contact ASCENDpbm Member Services at:
Phone: 833-200-5040
www.ASCENDpbm.com

Fraud Prevention: Any person who knowingly and with the intent to defraud any insurer or self-insured, presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.