National Script

500 Discovery Parkway | Suite 375
Superior, Colorado 80027
Fax: 303-628-2105

MEMBER REIMBURSEMENT FORM

Member Name: _____

Member ID Number: _____

Member Address: _____

_____

Employer Name: _____

PRESCRIPTION FILLED FOR: _____

Relationship to Member:
☐Self ☐Spouse ☐Dependent

RX Information:

Fill Date	Drug Name	NDC # (11 digit)	Quantity Dispensed	Drug Price

ATTACH DETAILED PRESCRIPTION RECEIPTS FOR EACH MEDICATION. YOUR CLAIM CANNOT BE PROCESSED WITHOUT A RECEIPT!