ScriptGuideRX Direct Member Reimbursement Form

*****PLEASE NOTE-A SEPARATE FORM MUST BE COMPLETED FOR EACH INDIVIDUAL PATIENT FOR SGRX TO PROCESS*****

1) This form **must** be filled out completely to process your claim(s).
2) Attach *all* prescription receipt(s) to the back of this form.
3) Prescription receipts must contain *all* of the following information *or* they will not be accepted: RX number, Date filled, Physician, Drug Name with National Drug Code (NDC#), Strength, Quantity, Days Supply and Prescription Charge.
4) The original paid pharmacy receipt(s) must accompany this form. Cash register receipt is not satisfactory proof of purchase.
5) Claims forms submitted without the required information can cause payment delays and result in the information being returned for completion.

Please sign the form and mail receipts to: ScriptGuideRX
PO BOX 14399 or email to: dmr@scriptguiderx.com
Detroit, MI 48214

If you have any questions or concerns please call member services at, 855-855-7479 Monday through Friday 8:30 am to 5:00 pm EST

Patient (Member) Information: (This is the individual whose name is on the ScriptGuideRX I.D. Card)
Please Print

Patient Name_____ Employer's Name_____

Mailing Address_____ Member ID_____

City_____State____Zip Code_____ Sex_____Date of Birth_____

Employee_____Spouse_____Child_____(Place an "X" for who the prescriptions are for)

Prescription Information:

Rx Number	Pharmacy Name	Date Rx Filled	Physician's Name and / or DEA Number	Drug Name and Strength NDC #	DIN/NDC (National Drug Code)	Quantity	Days Supply	Amount Paid

I hereby certify that the above statements, including accompanying statements, are to the best of my knowledge true, correct, and complete. I hereby authorize any physician or service provider to furnish and disclose all known facts concerning this claim(s) upon request from the claims administrator. I will reimburse the fund for any overpayment made to me or on my behalf due to error on this form.

EMPLOYEE SIGNATURE:_____ **DATE:**_____