AvantaRx

Member Reimbursement Form

This form is intended for use in reimbursement of pharmacy claims only. The filing of this form does not guarantee reimbursement. Please consult your plan documents for additional coverage information. If you have any questions regarding this form, or require additional forms please contact the AvantaRx Customer Care Team at (800) 724-8536.

1. Patient Information Use a separate claim form for each covered member of the family

IDENTIFICATION NUMBER		GROUP NUMBER
LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		
CITY	STATE (XX)	ZIP CODE (XXXXX)
DATE OF BIRTH MM/DD/YYYY)	RELATION TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	SEX ☐ M ☐ F
EMAIL ADDRESS (REQUIRED FOR REIMBURSEMENT)		PHONE NUMBER (XXX) XXX-XXXX

2. Prescriber Information

PRESCRIBER LAST NAME	PRESCRIBER FIRST NAME
PRESCRIBER PHONE NUMBER (XXX) XXX-XXXX	PRESCRIBER FAX NUMBER (XXX) XXX-XXXX

3. Review, Confirm, and Sign

Be sure to check your answers above as well as the details sections on the back before signing. Also check that your receipts cover each point in Submission Requirements on the back of this page. Missing or illegible information may result in a delay or denial of your claim. When you're ready to send, ensure your receipts are attached, read the following notice, sign below, and mail the forms. Your claim will be processed within 45-days of receipt.

Fraud Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

When complete, mail this form to:
AvantaRx Reimbursement Service
7777 Washington Village Drive
Suite 170
Dayton, OH 45459

or fax to (937) 741-2563

I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

Need help filling out this form?
AvantaRx Customer Care Team (800) 724-8536

SIGNATURE	NAME	DATE MM/DD/YYYY)

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Release of Information: The submission of this claim form, for you or any of your dependents, authorizes the release of all information to applicable health care providers and all others involved in filling the prescriptions or processing the claims submitted.

Translated: By sending in this form, you give AvantaRx permission to contact whomever we may need to so we can get you your money back.

What Your Pharmacy Receipts Need To Show To Get a Reimbursement

- Participant Name
- Prescription Number
- Drug Name and NDC Number
- Metric Quantity/Days Supply
- Pharmacy Name and Address or NABP Number
- Purchase Date
- Total Charge

Once you've confirmed your **original pharmacy receipts** (not cash register receipts or photocopies, sorry) cover these points, please attach them to this form however you'd like.

Attach Receipts Here

P: 800.724.8536 | **E**: claims@avantarx.com

A: 7777 Washington Village Drive, Suite 170
Dayton, OH 45459

AvantaRx.com