DIRECT PRESCRIPTION DRUG REIMBURSEMENT

PHARMACY BenefitDirect

P.O. Box 5300
Poland, OH 44514
800.800.PDMI (7364), ext. 5402

EMPLOYEE MUST COMPLETE THIS SIDE **PLEASE PRINT**

The undersigned certifies that the medication described hereon was received for the named person who is eligible for drug benefits, and that this medication is not for an on-the-job injury of a covered benefit by other insurance. The undersigned authorizes release of all information contained hereon to Pharmacy Data Management, Inc., or its agents, to sponsors, carriers, or health providers, and further authorizes use of member's social security number as the identification.

SIGNATURE OF PATIENT OR GUARDIAN OR LEGAL REPRESENTATIVE X

DRUG CARD INFORMATION	
GROUP NUMBER	MEMBER ID NUMBER

PATIENT'S FIRST NAME | BIRTH DATE

PATIENT IS:

- ☐ MALE
- ☐ FEMALE
- ☐ EMPLOYEE
- ☐ SPOUSE
- ☐ CHILD

PRINT

CARDHOLDER NAME FIRST INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

THIS CLAIM MUST BE FILED WITHIN 90 DAYS OF PURCHASE

PHARMACY LABEL OR FULL NAME AND ADDRESS

PHARMACY INFO MUST BE COMPLETED ON THIS SIDE **PLEASE PRINT**

CLAIM NUMBER X

PHARMACY ACCOUNT NUMBER

DATE OF THIS SERVICE

PRESCRIPTION NUMBER

METRIC QUANTITY DISPENSED CC TABS GM CAPS

1 ☐ NEW
2 ☐ REFILL

DAYS SUPPLY

NDC

PRINT

DRUG NAME STRENGTH

MANUFACTURER'S NAME

PRESCRIBER'S DEA NUMBER CIRCLE ONE MD DO DDS POD

TOTAL Rx CHARGES $

PHARMACIST'S SIGNATURE