

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 IS:

MALE SPOUSE
 FEMALE CHILD
 EMPLOYEE

PATIENT'S FIRST NAME BIRTH DATE

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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

PHARMACY ACCOUNT NUMBER

X

DATE OF THIS SERVICE

PRESCRIPTION NUMBER

METRIC CC GM

TABS CAPS

1 NEW
 2 REFILL

DAYS SUPPLY

D	N	D	C								
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DRUG NAME

STRENGTH

MANUFACTURER'S NAME

PRESCRIBER'S DEA NUMBER

CIRCLE ONE: MD DO DDS POD

PHARMACIST'S SIGNATURE

TOTAL Rx CHARGES

\$