Direct Member Reimbursement: DMR

Prescriptions must be filled at a MedImpact network pharmacy, except in the case of accidental injury or medical emergency.

Prescriptions that are filled at a non-network pharmacy may be sent to MedImpact using the "Prescription Claim Form".

The Member must attach their paid receipt to the claim form.

MedImpact will review and process. The member will be reimbursed for their out of pocket cost, minus any applicable copay amounts.

If the Member receives a denial from MedImpact, they should send the MedImpact denial form along with a note indicating the reason for the use of a non network pharmacy directly to KPS Health Plans.

KPS will review and if approved, will return the form to MedImpact with instructions to allow.

The member will then be reimbursed for their out of pocket cost, minus any applicable copay amounts.

If KPS Health Plans denies coverage, the Member may appeal...

Direct Member Reimbursement Prescription Claim Form

Health Plan ____ **Subscriber ID Number** _ _ _ _ _ _ _ _ _ _- -_ _

Subscriber Name ______________________________ ________________________ ______________________________
(Please print) First Middle Last

_________________________________ ____________________________ _________ ___________
Address City State ZIP Code

______________________________ ________________________________
Daytime Phone (including area code) Evening Phone (including area code)

Prescriptions Were Dispensed To:

Patient Name _____________________________ ___________________________ _________________________________
First Middle Last

Patient Birth Date: __________________ Male ___ Female ___ Relationship to Subscriber: Self __ Spouse __ Child __

Is this medication for an on-the-job injury? Yes __ No __

Is this medication covered under any other group insurance plan? Yes __ No __

If yes, provide the name of the insurance company and other employer. ____
Name of Insurance Company

~~~~~~~~~~~ NOTE ~~~~~~~~~~~

When submitting for Coordination of Benefits, co-pay only, the following documentation must be provided in order to process dual coverage claims.

1. **Both name and ID number under primary insurance and secondary insurance co.**
2. **Pharmacy receipt that identifies the primary insurance company and the amount paid OR…….**
3. **Explanation of Benefits from the primary insurance company.**

- **If the secondary insurance co. does not cover "Coordination of Benefit", the claim will be rejected and returned to you accordingly.**
- **Your cooperation will help us process your claims in a timely manner.**

Note: Use a separate claim form for each covered member of the family.

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Signature ____
Patient (or Parent if a Minor)

★ **Please attach the duplicate pharmacy generated receipt to this form. If it is unavailable, please have the pharmacy or dispensing facility complete the section below.**

Pharmacy or dispensing facility needs to complete the remaining portion and return this to member. Shaded areas are optional; please complete those areas if information is available.

	Date Filled	Check One	Quantity	Directions	Days Supply	Rx Price w/Tax
1)		New___ Refill___				
Medication Name, Form, & Strength			**DAW**	**M.D. DEA#**	**NDC Number (11 digits)**	
Rx Number 2)	**Date Filled**	**Check One** New__ Refill__	**Quantity**	**Directions**	**Days Supply**	**Rx Price w/Tax**
Medication Name, Form, & Strength			**DAW**	**M.D. DEA#**	**NDC Number (11 digits)**	

Pharmacy Name ______________________________

Address ____________________________________

City ______________ State _______ ZIP ________

If purchased in a foreign country, the currency must be converted into US dollars. Diagnosis and description of the drug is also required for claim processing.

Pharmacy NABP (Required) ______________________________________

Pharmacy Phone ____

Pharmacist's Signature ____
Note: Pharmacist's signature required when bottom portion of claim form is completed by pharmacy or dispensing facility only.

MedImpact Healthcare Systems, Inc. ■ 10680 Treena Street 5th floor ■ San Diego, CA 92131

For assistance with this form, please contact our DMR department at (858) 566-2727.