



# DIRECT REIMBURSEMENT CLAIM FORM

Please read carefully before completing this form. Payment will be delayed unless information is completed. Please tape pharmacy receipts to reverse side of claim form or attach the explanation of benefits from your primary payer.

FAX: 516-605-6980  
Attention: Claims Department

MAIL: **NMHC**RX, Attention: Claims Department  
P.O. Box 1170  
Port Washington, N.Y. 11050

<b>CARDHOLDER INFORMATION</b>					
Cardholder Last Name		Cardholder First Name		Cardholder Date of Birth	
Cardholder ID Number		Other Insurance (if any)		Cardholder Phone Number	
Cardholder Street Address			City	State/Prov	Zip Code
<b>PATIENT INFORMATION</b>					
Patient Last Name		Patient First Name		Patient Date of Birth <input type="checkbox"/> F <input type="checkbox"/> M	
<b>PHARMACY INFORMATION</b>					
Pharmacy Name				NABP Number	
Pharmacy Street Address			City	State/Prov	Zip Code
<b>CLAIM INFORMATION (1)</b>					
Date of Service		RX Number	Name, Strength and Form of Medication		Amount Paid
NDC (National Drug Code)		Quantity	Day Supply	Physician's Name	Physician's DEA
<b>CLAIM INFORMATION (2)</b>					
Date of Service		RX Number	Name, Strength and Form of Medication		Amount Paid
NDC (National Drug Code)		Quantity	Day Supply	Physician's Name	Physician's DEA
<b>CLAIM INFORMATION (3)</b>					
Date of Service		RX Number	Name, Strength and Form of Medication		Amount Paid
NDC (National Drug Code)		Quantity	Day Supply	Physician's Name	Physician's DEA
<b>CLAIM INFORMATION (4)</b>					
Date of Service		RX Number	Name, Strength and Form of Medication		Amount Paid
NDC (National Drug Code)		Quantity	Day Supply	Physician's Name	Physician's DEA

I certify that patient information entered on this form is correct and the named patient is eligible for the benefits claimed and has received the medication described. I also certify that this medication received is not for the treatment of an on-the job injury. I authorize **NMHC**RX to release all information pertaining to this claim to the plan administrator, underwriter, sponsored policy holder and/or the employer, including HIV related information, mental health treatment and/or alcohol/substance abuse treatment. I understand that payment of this claim will be made to the cardholder unless otherwise specified within this documents. I also certify that I personally have incurred this expense and am entitled to reimbursement.

Signature of Patient or Guardian or Legal Representative **X**

**SIGNATURE REQUIRED FOR REIMBURSEMENT**





**DIRECT REIMBURSEMENT CLAIM FORM**

**Please affix pharmacy receipts below**

**ATTACH  
PHARMACY  
RECEIPT  
HERE**

**ATTACH  
PHARMACY  
RECEIPT  
HERE**

**ATTACH  
PHARMACY  
RECEIPT  
HERE**

**ATTACH  
PHARMACY  
RECEIPT  
HERE**

**Before Mailing, Did You...**

Fill out the form completely? Sign your claim form? Attach all of your pharmacy receipts?

**Mail Completed Forms to:**

*NMHC*RX, Attention: Claims Department, P.O. Box 1170, Port Washington, N.Y. 11050

You can obtain additional forms by calling our Customer Service Department at 1-800-645-3332 or visiting our website [www.nmhcrx.com](http://www.nmhcrx.com)