DIRECT MEMBER REIMBURSEMENT FORM

motivhealth®

Please Note: A separate form must be completed for each individual patient for SGRX to process.

1. This form **must** be filled out to completely process your claim(s).

2. Attach all prescription receipt(s) to the back of this form.

3. Prescription receipts must contain all of the following information or they will not be accepted:
RX Number, Date Filled, Physician, Drug Name with National Drug Code (NDC#), Strength, Quantity, Days Supply, and Prescription Charge.

4. The original paid pharmacy receipt(s) must accompany this form. Cash register receipt is not satisfactory proof of purchase.

5. Claims forms submitted without the required information can cause payment delays and result in the information being returned for completion.
Please sign the form and mail receipts to:

ScriptGuideRX
PO BOX 14399
Detroit, MI 48214

or email to:

drm@scriptguiderx.com

If you have any questions or concerns please call member services:
855-855-7479
Monday - Friday
8:30 am - 5:00 pm EST.

Patient (Member) Information:

(This is the individual whose name is on the ScriptGuideRX ID Card.) Please print:

Patient Name: _____ Employer Name: _____

Mailing Address: _____ Member ID: _____

City: _____ State: _____ Zip Code: _____ Sex: _____ Date of Birth: _____

Check the box next to who the prescriptions are for: ☐ Employee ☐ Spouse ☐ Child

Prescription Information:

Rx Number:	Pharmacy Name:	Date Rx Filled:	Physician's Name and/or DEA Number:	Drug Name, Strength, NDC #:	DIN/NDC (National Drug Code):	Quantity:	Days Supply:	Amount Paid:

I hereby certify that the above statements, including accompanying statements, are to the best of my knowledge true, correct, and complete. I hereby authorize any physician or service provider to furnish and disclose all known facts concerning this claim(s) upon request from the claims administrator. I will reimburse the fund for any overpayment made to me or on my behalf due to error on this form.

Employee Signature: _____ **Date:** _____