Direct Member Reimbursement Form

Name: Last: _____ First : _____ MI: _____

Mailing Address: _____

Identification Number (printed on prescription card): _____

Group Name: _____Group Number: _____

Please attach a detailed receipt from the pharmacy to this form. If the information in the table below is not provided on the receipt, please have the pharmacist fill in the table and attach proof of payment.

Rx #	NCPDP #	Fill Date	Drug Name	NDC #	MD Name	Quantity Filled	Rx Price	Days' Supply

Mail to **Araya**
Attention: Claims Dept.
PO Box 460
Latham, NY 12110

Please Note: You will be reimbursed according to your plan's specific benefit design