GRANITE ALLIANCE
INSURANCE COMPANY

Reimbursement Form

Directions

1. This form must be completely filled out to process your claim(s)
2. Attach a copy of all prescription receipt(s) to the back of this form
3. Please submit within 3 years from the date the prescription was obtained
4. Prescription receipts should contain as much of the following information as possible;
   a. Prescription number and date filled
   b. Pharmacy name and telephone number
   c. Drug name and strength
   d. Quantity, day supply, and amount paid

5. Mailed:
   Granite Alliance Insurance Company
   P.O. Box 1382
   Maryland Heights, MO 63043

   OR Faxed:
   1-888-656-8099

6. If you have any questions please contact us, Granite Alliance Insurance Company at **1-855-586-2573** (TTY users call 711). We are available 24 hours a day, 7 days a week.

Member Information

Member Full Name:	Member ID Number:
Mailing Address:	Phone Number:
City: State:	Zip:

You did not receive coverage at the pharmacy because:

- ☐ You have not received your ID Card
- ☐ The pharmacy is not in the Granite Alliance Insurance Company network
- ☐ The pharmacy cannot process the claim electronically
- ☐ It was an emergency - Please describe the emergency on a separate sheet
- ☐ The pharmacy or payer system was down
- ☐ You did not have your ID card and the pharmacy could not verify eligibility
- ☐ There were not any network pharmacies available where the prescription could be filled
- ☐ Other - Please describe on a separate sheet

Other Insurance Coverage Information
Are you eligible for primary prescription drug coverage from another insurance company?
☐ Yes
☐ No
Other Insurance Company's Name:
Group Number:
Member ID Number:
Effective Date of Coverage:

Prescription Information							
#	Rx Number	NDC Number	Compound Y/N	Date Filled (mm/dd/yyyy)	Drug Name/Strength	Amount Paid	Quantity/Day Supply
1							
2							
3							
4							

Pharmacy Information			
#	Pharmacy Name	Pharmacy Phone Number	Pharmacy NPI Number
1			
2			
3			
4			

Prescriber Information				
#	Prescriber Name	NPI Number	Phone Number	State
1				
2				
3				
4				

Enrollee Signature

AR, CA, DC, FL, HI, MD, ME, OK, TN, TX, UT, VA, WA, WV, Residents: WARNING - For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information is guilty of a crime and may be subject to imprisonment, fines and/or denial of insurance benefits. **Additionally, AR, CA, FL, MD, ME OK, TC, UT, WV Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or confinement in prison.

I certify that the individual for whom this claim is made is a covered person in this Prescription Drug Program and that the prescription is for the sole use of the named individual. I authorize Granite Alliance Insurance Company, health care providers, and/or persons or entities retained by Granite Alliance Insurance Company, for the purpose of auditing claims to secure or release information related to this claim. I understand, agree, and consent that this authorization shall remain in effect indefinitely.

Signature: _____ **Date: _____**

REMINDER:
To avoid having to submit a paper claim

- ✓ Always have your prescription drug card at the time of purchase
- ✓ Always use pharmacies in your network
- ✓ Use medication covered under your formulary