Granite Alliance Insurance Company (PDP)
P.O. Box 1382
Maryland Heights, MO 63043
www.mygraniterx.com

Foreign Reimbursement Form

Directions

1. This form must be completely filled out in order to process your claim(s).
2. Attach a copy of all prescription receipt(s) to the back of this form.
3. Please submit within 12 months from the date the prescription was obtained.
4. Prescription receipts should contain as much of the following information as possible:
   - Prescription Number and Date filled
   - Pharmacy Name and Telephone Number
   - Drug Name and Strength
   - Quantity, Day Supply and Amount Paid
5. Mailed:
   Granite Alliance
   P.O. Box 1382
   Maryland Heights, MO 63043
   Attention: Foreign Claims

   OR

   Faxed:
   888-656-8099
6. If you have any questions please contact us, Granite Alliance, 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 #:
Mailing Address:		Phone Number:
City:	State:	Zip:

Prescription Information

Country Visited: _____ **Currency Type Paid with: _____**

#	Date Filled (mm/dd/yyyy)	Drug Name/Strength	Quantity/Day Supply	Foreign Amount Paid
1				
2				
3				
4				

Pharmacy Information		
#	**Pharmacy Name**	**Pharmacy Phone #**
1		
2		
3		
4		

Consent

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: _____**

Important Claims Notice

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, TX, 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.