

Reimbursement Form

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- 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 Attn: MPD 1000UR

P.O. Box 64810

St. Paul, MN 55164-0811

OR Faxed:

888-656-8099

If you have any questions, please call Customer Service at **855-586-2573**, (TTY users call 711). Representatives are available 24 hours a day, 7 days a week.

| | Member Informa | tion |
|-------------------|----------------|-------------------|
| 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 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 y | Are you eligible for primary prescription drug coverage from another insurance company? | | | | | | | | |
| | ☐ Yes | | | | | | | | |
| | □ No | | | | | | | | |
| Other | Other Insurance Company's Name: | | | | | | | | |
| Grou | Group Number: | | | | | | | | |
| Member ID Number: | | | | | | | | | |
| Effec | tive Date of Cove | erage: | | | | | | | |
| | | | | | | | | | |
| | Prescription Information | | | | | | | | |
| # | Rx Number | NDC Number | Compound Y/N | Date Filled (mm/dd/yyyy) | 0 | | Amount Paid | Quantity/Day Supply | |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| | | | | | | | | | |
| | | | Pharmac | y Information | 1 | T | | | |
| # | Pharmacy Name | | Pharma | er | Pharmacy NPI Number | | | | |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| | | | | | | | | | |
| | | | Prescribe | r Information | 1 | | | | |
| # | Prescrib | er Name | NPI Number | | Phone Number | | State | | |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| | | | | | | | | | |
| 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 | | | | | | | | |