MEMBER REIMBURSEMENT DRUG CLAIM FORM

UFCW & EMPLOYERS BENEFIT TRUST (UEBT)

catamaran™

Please mail this claim form directly to:
Catamaran Manual Claims
P.O. Box 968021
Schaumburg IL 60196-8021

For assistance please call:
(8 6 6) 6 3 5 - 6 9 0 6
24 hours a day, 7 days a week

Please print or type this information

RxGrp# | | | | | | | | I.D. # (SSN) | | | | - | | | - | | | | |
(See ID Card for number)

Plan/Employer Name: (**REQUIRED**)

Cardholder's Last Name | First Name: | Middle Initial

Cardholder's Street Address: | City: | State: | Zip:

( ) | | | | — | | | | | ( ) | | | | — | | | | |
Cardholder's Day Time Phone Number: | Cardholder's Evening Phone Number:

Patient's Name: (Use a separate claim form for each covered family member) | Patient's Date of Birth | / | /

☐ Female ☐ Male
Patient Gender

☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner
Patient's relationship to cardholder

CHECK REASON FOR SUBMISSION (if applicable)

Reasons checked must apply to all prescriptions. If submitting prescription label receipts for different reasons, please use a separate form.

☐ Reimbursement of co-payments (other prescription insurance, dual coverage or COB)

☐ Eligibility issue that could not be resolved through Fund Office at time of receiving the prescription

☐ Depo Provera when dispensed by Kaiser for administration at a Kaiser facility

☐ Compound Medication

☐ Special Distributors (not related to Specialty drugs.) This exception is for certain medications such as Xolair, Nexvar, Exjade, and Kuvan which can only be purchased through certain distributors.

☐ No UEBT Network Pharmacy within 10 miles of home or work. Please provide your work address below.

Work Address: _____

☐ Emergency (please explain) _____

CLAIM WILL BE RETURNED IF REQUIRED INFORMATION IS MISSING

Date: _____ Employee's Signature _____

I certify that all information on this claim form is accurate. I understand that Catamaran Inc.'s use or disclosure of individually identifiable health information, whether furnished by me or obtained from another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

MEMBER REIMBURSEMENT DRUG CLAIM FORM (CONTINUED)

RxGrp# | | | | | | | | I.D. # (SSN) | | | | - | | | - | | | | |
(See ID Card for number)

WITHOUT PHARMACIST SIGNATURE - PHARMACY LABEL RECEIPTS ARE REQUIRED

Date:_____ Pharmacist's Signature:_____

1 Fill date _____ RX#_____ Quantity _____ Day Supply _____

Drug Name _____

NDC # | | | | | | | | | | | |

Pharmacy NPI | | | | | | | | | | |

Pharmacy Address & Phone Number

Amount You Paid. $ _____ ☐ Full Price ☐ Co-Pay

☐ Compound ☐ Regular Rx

2 Fill date _____ RX#_____ Quantity _____ Day Supply _____

Drug Name _____

NDC # | | | | | | | | | | | |

Pharmacy NPI | | | | | | | | | | |

Pharmacy Address & Phone Number

Amount You Paid. $ _____ ☐ Full Price ☐ Co-Pay

☐ Compound ☐ Regular Rx

3 Fill date _____ RX#_____ Quantity _____ Day Supply _____

Drug Name _____

NDC # | | | | | | | | | | | |

Pharmacy NPI | | | | | | | | | | |

Pharmacy Address & Phone Number

Amount You Paid. $ _____ ☐ Full Price ☐ Co-Pay

☐ Compound ☐ Regular Rx

4 Fill date _____ RX#_____ Quantity _____ Day Supply _____

Drug Name _____

NDC # | | | | | | | | | | | |

Pharmacy NPI | | | | | | | | | | |

Pharmacy Address & Phone Number

Amount You Paid. $ _____ ☐ Full Price ☐ Co-Pay

☐ Compound ☐ Regular Rx

CLAIM WILL BE RETURNED IF REQUIRED INFORMATION IS MISSING

Cash register receipts are not accepted. Please make copies for your records - documents will NOT be returned.

Questions? Call (866) 635-6906

UEBT 8/24/12