



224 North Park Ave • Fremont, NE 68025  
Phone: (402) 753-2800 • Fax: (888) 810-1394

## Reimbursement Request Form

*Note: Please send to the attention of the "Reimbursement Department" when mailing this form to Sav-Rx.*

### Participant Information

Cardholder Name (See ID Card):

Cardholder ID (See ID Card):

Relation to Cardholder:  Self  Dependent

Participant Name:

Date of Birth:

Phone Number:

Email Address:

Address:

City:

State:

Zip Code:

### Prescription Information

Number of Prescriptions Submitted:

Date Prescription(s) Filled:

*(For multiple prescriptions please use a range from first to last)*

Out-of-Pocket Total:

Coupon Used At Time Of Processing:  Yes  No

### Reimbursement Information

In the space below, please provide the reason for not utilizing the Sav-Rx card/ submitting this reimbursement request:

**Please provide receipts for prescriptions along with this form.**

*Please note any receipts submitted to Sav-Rx for reimbursement must include the following*

- Member Name
- Date of Service
- Drug Name
- Quantity Dispensed
- Amount Patient Paid
- Drug NDC
- Prescription Number

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Date

By signing the above, you attest that all information is true to the best of your abilities in seeking reimbursement for medications paid out of pocket and/ or that did not adhere to the benefit structure – resulting in a larger amount paid. You also acknowledge that there is no guarantee of reimbursement for medications that may have required a prior authorization or clinical review prior to dispensing the medication(s).