

Bluegrass Family Health

PRESCRIPTION REIMBURSEMENT

★REQUESTS THAT ARE INCOMPLETE WILL BE RETURNED★

- REIMBURSEMENT GIVEN AT THE USUAL AND CUSTOMARY RATE
- SEPARATE FORMS ARE REQUIRED FOR EACH MEMBER
- INCLUDE RECEIPT FOR EACH PRESCRIPTION
- SUBMITTING THIS FORM IS NOT A GUARANTEE FOR PAYMENT
- REQUESTS ARE SUBJECT TO ALL PLAN RULES AND REQUIREMENT

PRESCRIPTION INFORMATION

Name _____ ID# _____ DOB _____

Address _____ City/State/Zip _____

1.	_____	_____	_____	_____	_____	_____
	Drug	NDC	Date	Quantity	Day Supply	Price
2.	_____	_____	_____	_____	_____	_____
	Drug	NDC	Date	Quantity	Day Supply	Price
3.	_____	_____	_____	_____	_____	_____
	Drug	NDC	Date	Quantity	Day Supply	Price
4.	_____	_____	_____	_____	_____	_____
	Drug	NDC	Date	Quantity	Day Supply	Price

Pharmacy _____ NABP# _____

Address _____ City/State _____ Zip _____

Request Reason _____

PRIMARY CARDHOLDER INFORMATION

Name _____ ID# _____ Phone (____) _____

Address _____ City/State/Zip _____

ADDITIONAL INSURANCE CARRIER

Insurance Carrier _____

Cardholder Name _____ ID# _____

Mailing address:
Bluegrass Family Health
Pharmacy Reimbursement
651 Perimeter Drive
Suite 300
Lexington, KY 40517

RA04/05.84

- NABP and NDC numbers available at pharmacy
- Retain copies for your records
- Allow 6-8 weeks for reimbursement
- Contact us at (877) 205-6308 or by fax (859) 335-3744