



ClaimLinx
10260 Alliance Road
Suite 130
Cincinnati, OH 45242
(513) 677-6262 or (800) 858-1772 Phone
(513) 677-6263 or (800) 858-1913 Fax
www.claimlinx.com

Benefit Administration That's Personal!

How to Get Reimbursed for a Prescription

Your employer has decided to reimburse you for prescription drug benefits as outlined in your Prescription Reimbursement Schedule of Benefits.

To file a Prescription Reimbursement Claim:

- ✓ Visit a pharmacy as outlined in your major medical carrier coverage directory. Most carriers have the directories outlined on their website, or refer to the documentation received in your major medical carrier member packet.
- ✓ Keep the receipt you receive from your pharmacist and make a copy for your files
- ✓ Complete the enclosed Prescription Expense Reimbursement Form
- ✓ Send the Prescription Expense Reimbursement Form along with a copy of the prescription receipt to our office.
- ✓ Please send via fax or regular mail
- ✓ You will receive an explanation of benefits in the mail from ClaimLinx indicating your reimbursement amount.
- ✓ Reimbursement checks for prescription drugs are mailed directly to member's address on file

Remember.....

- keep a copy of your receipt and claim for your records
- do not send poorly reproduced copies
- ClaimLinx must be able to read the name, date of service, type of drug, etc. in order to process a reimbursement
- Store receipts are not eligible for reimbursement. ClaimLinx must receive a copy of the actual drug dispensation documentation in order to process a claim.

****CONTACT OUR OFFICE IF YOU HAVE ANY QUESTIONS****



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Prescription Expense Reimbursement Form

NOTE: Please fax or mail and attach RX receipt(s) to process your request.

Today's Date: _____ # Pages _____
(include coversheet)

Company: _____

Employee Name: _____
(Please Print Clearly – First Name, MI, Last Name)

Relationship: S = Self / SP = Spouse / CH = Child

	Drug Dispensation Date	Claimant Name	Relationship to Employee (Circle)	Prescription Expense Type (Circle)		Employee Paid	Reimbursement Amount
				Retail	Mail Order		
1			S / SP / CH	Gen/Brand /Non-Form	Gen/Brand /Non-Form		
2			S / SP / CH	Gen/Brand /Non-Form	Gen/Brand /Non-Form		
3			S / SP / CH	Gen/Brand /Non-Form	Gen/Brand /Non-Form		
4			S / SP / CH	Gen/Brand /Non-Form	Gen/Brand /Non-Form		
5			S / SP / CH	Gen/Brand /Non-Form	Gen/Brand /Non-Form		
6			S / SP / CH	Gen/Brand /Non-Form	Gen/Brand /Non-Form		
7			S / SP / CH	Gen/Brand /Non-Form	Gen/Brand /Non-Form		
		TOTAL					\$

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