



CBCA PHARMACY BENEFITS
675 FOXON ROAD, SUITE 204
EAST HAVEN, CT 06513

DIRECT MEMBER
REIMBURSEMENT FORM (DMR)

<p>EMPLOYER NAME: _____ GROUP NUMBER: _____</p> <p>EMPLOYEE NAME _____</p> <p>MEMBER ID NUMBER _____</p> <p>ADDRESS _____</p> <p>CITY _____ STATE _____ ZIP _____</p> <p>PATIENT NAME: _____ GENDER _____</p> <p>RELATIONSHIP TO EMPLOYEE _____ DATE OF BIRTH _____</p>	<ol style="list-style-type: none"> 1. Please complete a separate claim (DMR) form for each member of the family. 2. Please print and include all information requested. You may need to contact your pharmacy for the necessary information. 3. <u>The ORIGINAL paid pharmacy receipt(s) must accompany this form.</u> Photocopies or cash register receipts are not satisfactory evidence of purchase. 4. Retain copies of supporting documentation for your records as those submitted cannot be returned. 5. Reimbursement is based on the pharmacy-contracted rate and may be less than the actual cash price paid.
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I CERTIFY THAT THE PATIENT FOR WHOM THIS CLAIM (S) IS MADE IS A COVERED PERSON IN THIS PRESCRIPTION DRUG PROGRAM AND THAT THE PRESCRIPTION IS FOR THE SOLE USE OF THE NAMED PATIENT. I ALSO CERTIFY THAT THE CLAIM (S) BEING SUBMITTED FOR PAYMENT ARE NOT ELIGIBLE FOR PAYMENT UNDER A NO-FAULT AUTOMOBILE OR WORKER'S COMPENSATION INSURANCE PROGRAM. I ALSO AUTHORIZE RELEASE OF ALL INFORMATION PERTAINING TO THIS CLAIM TO THE PLAN ADMINISTRATOR OR THEIR REPRESENTATIVE. **Authorized Signature** **X** _____

Name and Address of Pharmacy	Pharmacy ID Number								
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	Prescription Number	New/ Refill	Quantity	Days Supply	Date of Purchase	Name of Drug (compounds see reverse side)	Physician Name & DEA Number	National Drug Code (NDC)	Amount Paid
Claim 1									\$
Claim 2									\$
Claim 3									\$
Claim 4									\$

FORMS NOT FULLY COMPLETED WILL BE RETURNED