

# Pharmacy Claims Member Reimbursement Form

For use only by Dean Health Plan Members



- Step 1** Fill out form completely, providing information for up to three prescriptions. Ask your pharmacy to provide the information requested on this form that may not be familiar to you.
- Step 2** Attach prescription label and receipt of payment for prescription(s). This can be in the form of a cash register receipt, prescription information slip or patient medication profile report.
- Step 3** Mail to address printed at bottom of form.

Member Information			Pharmacy Information		
Name			Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Telephone ( )			Telephone ( )		
Dean Member #		Group #	Pharmacy Number (NABP)		

 **Dean is Member's** (circle all that apply)    primary    secondary    other    **health insurance.**

1

Prescription Information			
℞ number	Product Name/Strength/Dosage Form		
NDC #	Quantity	Days Supply	Date of Service
Prescriber's Full Name			
<b>Prescription Cost and Reimbursement</b>		<b>Other Insurance Coverage Coverage</b> (please check all that apply and include documentation of payment or rejection from other insurer)	
Amount paid by Member for prescription	\$ <input style="width: 80px;" type="text"/>	<input type="checkbox"/> This prescription has been submitted to an insurance company other than Dean for payment. <input type="checkbox"/> Other insurance rejected the prescription and did not pay for any portion of it. <input type="checkbox"/> Other insurance paid for a portion of the prescription.	
Amount Member requesting to be reimbursed for prescription	\$ <input style="width: 80px;" type="text"/>		
Additional Comments/Information			

2

℞ number	Product Name/Strength/Dosage Form		
NDC #	Quantity	Days Supply	Date of Service
Prescriber's Full Name			
<b>Prescription Cost and Reimbursement</b>		<b>Other Insurance Coverage Coverage</b> (please check all that apply and include documentation of payment or rejection from other insurer)	
Amount paid by Member for prescription	\$ <input style="width: 80px;" type="text"/>	<input type="checkbox"/> This prescription has been submitted to an insurance company other than Dean for payment. <input type="checkbox"/> Other insurance rejected the prescription and did not pay for any portion of it. <input type="checkbox"/> Other insurance paid for a portion of the prescription.	
Amount Member requesting to be reimbursed for prescription	\$ <input style="width: 80px;" type="text"/>		
Additional Comments/Information			

3

℞ number	Product Name/Strength/Dosage Form		
NDC #	Quantity	Days Supply	Date of Service
Prescriber's Full Name			
<b>Prescription Cost and Reimbursement</b>		<b>Other Insurance Coverage Coverage</b> (please check all that apply and include documentation of payment or rejection from other insurer)	
Amount paid by Member for prescription	\$ <input style="width: 80px;" type="text"/>	<input type="checkbox"/> This prescription has been submitted to an insurance company other than Dean for payment. <input type="checkbox"/> Other insurance rejected the prescription and did not pay for any portion of it. <input type="checkbox"/> Other insurance paid for a portion of the prescription.	
Amount Member requesting to be reimbursed for prescription	\$ <input style="width: 80px;" type="text"/>		
Additional Comments/Information			



Mail to: Navitus Health Solutions,  
P.O. Box 999, Appleton, WI 54912-0999



For Questions: Call Dean Health Plan Customer Service, (608) 828-1301 or (800) 279-1301