

## **Reimbursement Form**

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- 1. This form must be completely filled out to process your claim(s)
- 2. Attach a copy of all prescription receipt(s) to the back of this form
- 3. Please submit within 3 years from the date the prescription was obtained
- 4. Prescription receipts should contain as much of the following information as possible;
  - a. Prescription number and date filled
  - b. Pharmacy name and telephone number
  - c. Drug name and strength
  - d. Quantity, day supply and amount paid
- 5. Mailed:

**Granite Alliance Insurance Company Attn: MPD 1000UR** 

P.O. Box 64810

St. Paul, MN 55164-0811

OR Faxed:

888-656-8099

If you have any questions, please call Customer Service at **855-586-2573**, (TTY users call 711). Representatives are available 24 hours a day, 7 days a week.

	Member Informa	tion
Member Full Name:		Member ID Number:
Mailing Address:		Phone Number:
City:	State:	Zip:

You did not receive coverage at the pharmacy because:
☐ You have not received your ID Card
☐ The pharmacy is not in the network
☐ The pharmacy cannot process the claim electronically
☐ It was an emergency - Please describe the emergency on a separate sheet
☐ The pharmacy or payer system was down
☐ You did not have your ID card and the pharmacy could not verify eligibility
☐ There were not any network pharmacies available where the prescription could be filled
☐ Other - Please describe on a separate sheet

Other Insurance Coverage Information									
Are y	Are you eligible for primary prescription drug coverage from another insurance company?								
	☐ Yes								
	□ No								
Other	Other Insurance Company's Name:								
Grou	Group Number:								
Member ID Number:									
Effec	tive Date of Cove	erage:							
	Prescription Information								
#	Rx Number	NDC Number	Compound Y/N	Date Filled (mm/dd/yyyy)	0		Amount Paid	Quantity/Day Supply	
1									
2									
3									
4									
			Pharmac	y Information	1	T			
#	Pharmacy Name		Pharma	er	Pharmacy NPI Number				
1									
2									
3									
4									
			Prescribe	r Information	1				
#	Prescrib	er Name	NPI Number		Phone Number		State		
1									
2									
3									
4									
REMINDER:									
To avoid having to submit a paper claim									
✓ Always have your prescription drug card at the time of purchase									
<b>√</b>	✓ Always use pharmacies in your network								
<b>✓</b>	✓ Use medication covered under your formulary								