ClaimLinx
10260 Alliance Road
Suite 325
Cincinnati, OH 45242
(513) 677-6262 or (800) 858-1772 Phone
(513) 677-6263 or (800) 858-1913 Fax
claims@claimlinx.com
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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 websites, or refer to the documentation in the major medical carrier member packet you should have received.
- ✓ Keep the receipt 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 the ClaimLinx office for processing.
- ✓ Please send this form via mail or fax or submit it through ClaimLinx's private member portal.
- ✓ 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 a 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 dispensing documentation in order to process a claim.**

****CONTACT OUR OFFICE IF YOU HAVE ANY QUESTIONS****
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Prescription Expense Reimbursement Claim Form

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

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

Company: _____

Employee Name: _____ **DOB**_____
(Please Print Clearly – First Name, MI, Last Name) *(Date of Birth)*

Relationship: S = Self / SP = Spouse / CH = Child
Prescription Expense Type: G = Generic / B = Brand / NF = Non-Formulary

	Date of Service	Claimant Name	Relationship to Employee (*Check Box*)	Prescription Expense Type		Employee Paid Amount	Reimbursement Amount
				Retail	Mail Order		
1			S / SP / CH ☐ ☐ ☐	G B NF ☐ ☐ ☐	G B NF ☐ ☐ ☐		
2			S / SP / CH ☐ ☐ ☐	G B NF ☐ ☐ ☐	G B NF ☐ ☐ ☐		
3			S / SP / CH ☐ ☐ ☐	G B NF ☐ ☐ ☐	G B NF ☐ ☐ ☐		
4			S / SP / CH ☐ ☐ ☐	G B NF ☐ ☐ ☐	G B NF ☐ ☐ ☐		
5			S / SP / CH ☐ ☐ ☐	G B NF ☐ ☐ ☐	G B NF ☐ ☐ ☐		
6			S / SP / CH ☐ ☐ ☐	G B NF ☐ ☐ ☐	G B NF ☐ ☐ ☐		
7			S / SP / CH ☐ ☐ ☐	G B NF ☐ ☐ ☐	G B NF ☐ ☐ ☐		
8			S / SP / CH ☐ ☐ ☐	G B NF ☐ ☐ ☐	G B NF ☐ ☐ ☐		
		TOTAL					$

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