southernscripts

Claim Reimbursement Form

Group Name:_____ **Original Submitted Claim Date**_____

Member ID Number:_____

Member's Last Name:_____**First Name**:_____

Primary Cardholder's Name: _____

Member's Phone Number:_____**Email:** _____

Address:_____**City**:_____**State**:_____**Zipcode**:_____

Patient's DOB:__/__/_____ Patient's Sex: ***Circle:*** F M

Relationship Code: ***Circle:*** Self Spouse Dependent

Receipts must be included with the following information:

Patient's Name, Rx Number, Doctor's Name or DEA Number, Pharmacy Name and Address (or NPI number), Medication Name and strength or NDC number, Metric Quantity and Day Supply, Purchase Date and Total Charge.

Return Receipts and Form via email, fax, or mail to:

Southern Scripts, LLC.
411 Bienville St
Natchitoches, LA 71457
P: (800) 710-9341
F: (318) 214-4190
support@southernscripts.net

Rx Number:	Quantity:	Day Supply:	Amount Paid:
			Total:

Disclaimer:
The submission of this Rx Claim form, for you or and dependents, authorizes the release of all information to the Plan Sponsor, Administrator and/or Pharmacy Benefit Manager

Certification:
I certify that the information on this form is correct. I also confirm that the patient for whom this claim is made has coverage at the time the claim was incurred.

Signature:_____Date:_____

For Internal Use Only:

Rx Number:	Amount:	Co-Pay:	Total:
Total:			

Total Amount Owed to Member: $ _____

Total Amount to Invoice Client: $ _____