



## Prescription Direct Member Reimbursement Form

Complete and return this form when you have paid full price for a prescribed prescription drug at retail cost and are seeking reimbursement.

**Submit this form with the original prescription label receipt(s). Cash register and credit card receipts alone are not acceptable as proof of purchase.**

**Reimbursement is not guaranteed as claims are still subject to plan benefit rules.**

### Patient Information (one form per patient)

Health Plan (Insurance) Name *(please print)*

Name *(Last Name, First Name, MI)*

Birth Date

I.D. Number

Mailing Address *(Number, Street, City, State & Zip Code)*

Prescribing Physician's Name

Physician's Telephone Number

### Reason For Request

*(At least one must be checked)*

- |                                                                                                     |                                                              |
|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Out of Area emergency medication                                           | <input type="checkbox"/> Compound medication                 |
| <input type="checkbox"/> Non-emergency medication/vacation request                                  | <input type="checkbox"/> Member not found in pharmacy system |
| <input type="checkbox"/> No identification card or identification number available                  | <input type="checkbox"/> Other: _____                        |
| <input type="checkbox"/> Coordination of Benefits (From Primary Insurance – complete section below) |                                                              |

I certify that the patient for whom this claim 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 workers compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder and/or employer.

X \_\_\_\_\_  
Member's/Subscriber's Signature

Date

### Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement may be delayed or denied. Please refer to example on the second page.

- |                                         |                                       |
|-----------------------------------------|---------------------------------------|
| • Pharmacy Name                         | • Prescription number and date filled |
| • Drug name, NDC, strength and quantity | • Member paid expense                 |
| • Prescribing physician's name          |                                       |

**The claim(s) will be returned if the member/subscriber's signature is not present.**

Please mail label receipt(s) and this completed form to:

**RightwayRx  
PO Box 996  
Attn: Paper Claims  
Portland, ME 04104**

Reimbursement will be issued to the primary member/subscriber.



### Example Prescription Label

Below is an example of a typical prescription label. Use this as a guide to confirm that all the necessary information is available on the pharmacy prescription label before submitting this form for reimbursement.

|                                                                    |            |                                                                                                 |
|--------------------------------------------------------------------|------------|-------------------------------------------------------------------------------------------------|
| XYZ Pharmacy<br>Store 1234<br>555 Street Road<br>New York, NY 1001 |            | Phone: 555-555-1212<br>Date of Fill: 01/01/2022<br>Physician Name: Dr. Smith<br>NPI: 1234567890 |
| Jane Doe                                                           | RX: 123456 |                                                                                                 |
| Take one (1) capsule by mouth three (3) times a day.               |            | Copay: \$5.00                                                                                   |
| Amoxicillin 500mg Capsules (TEVA)<br>NDC: 12345-1234-01            |            | Quantity: 30<br>Day Supply: 10<br>Refills Remaining: 1<br>Original Date: 01/01/2022             |



## **Frequently asked questions about Direct Member Reimbursement (DMR).**

What is direct member reimbursement or "DMR"?

DMR allows you to request reimbursement for out-of-pocket prescription costs covered by your plan.

When do I submit a DMR?

Submit a DMR when you have paid for a prescription out of pocket and didn't use your prescription card. You may also submit a DMR if you paid for a prescription at an out-of-network pharmacy.

How do I submit a DMR?

You can submit your DMR via the Rightway app, email it to [rwrx@rightwayhealthcare.com](mailto:rwrx@rightwayhealthcare.com), or mail the DRM form with your receipt and prescription details.

How long will it take to get reimbursed?

DMR claims are typically processed within 14 business days. Timing and reimbursement amounts may vary based on plan details.

Is there a deadline for submitting a reimbursement request?

DMR requests must be submitted within 180 days of the purchase of the prescription.

Questions?

Contact the Rightway Pharmacy team via the Rightway app or call the Rightway Pharmacy team at 888-665-1678.