GoodRx
Credit reimbursement request Form

Instructions for Submitting Form

Use this form to request credit reimbursement for covered medications purchased using GoodRx discount card.

Please print clearly or type.

DATE (mm/dd/yyyy)	MEMBER ID	GROUP NUMBER
MEMBER NAME (please print)		
MEMBER ADDRESS (city, state, ZIP)		
PATIENTS NAME		

Physician and Pharmacy information

Prescribing Physician Name

Dispensing Pharmacy Name

Prescribing Physician Phone Number with Area Code

Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: _____ **Date:** _____

1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information from pharmacy checklist below. If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
2. Read the Acknowledgement then sign and date.
3. Send completed form with pharmacy receipt(s) to:

MBA Benefit Administrators Claims Department
P.O. Box 57340
Murray, UT, 84157-0340

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions, and provisions.

Pharmacy Receipts for Reimbursement

Use the following checklist to ensure your receipts have all information required for your reimbursement request:

- Date prescription filled
- Name and address of pharmacy
- Prescribing physician name or ID number
- National Drug Code (NDC) number
- Name of drug and strength
- Prescription number (Rx number)
- Quantity