Prescription Drug Claim Form
For Yale Health Members

Use this claim form to request reimbursement for prescription drugs purchased:
• Between the effective date of your prescription coverage and the receipt of your card.
• When prescription drugs are purchased at a non-participating pharmacy.
  (Note: Only if allowed by your plan)

When filling out claim form (reverse side):
• Complete a separate form for each family member for whom prescription drugs were purchased.
• Complete the top portion of the form in full. **Incomplete forms will be returned to you.**
• Include the patient’s ID number.

Include copies of the prescription receipts showing the following information:
• Pharmacy Name, Address & Phone Number
• Patient Name
• Prescription Number
• Prescription Fill Date
• Drug Name, Strength and NDC Code
• Drug Quantity and Day Supply
• Drug Cost
• Amount Paid

Please mail the form and receipts to the following address:

Catamaran
P.O. Box 968022
Schaumburg, IL 60196-8022

If you have any questions regarding your Direct Member Reimbursement, please call Catamaran Member Services at (800) 763-0044.
Member Services Hours of Operation: 24 hours a day, 7 days a week.
Please read the instructions before completing this form. (PLEASE PRINT)

Subscriber Name: __________________________________________________________________________________________

First                 Middle                 Last

Mailing Address: __________________________________________________________________________________________

Street

________________________________________________________________________________________

City                 State                 Zip

Subscriber Date of Birth: ____ / ____ / ____

Patient Name: (if different from subscriber): __________________________________________________________________________________________

First                 Middle                 Last

Patient Member ID Number: __________________________

Status: □ faculty/staff/associate       □ student

Patient’s Date of Birth: ____ / ____ / ____

If your medication is covered under ANY OTHER Insurance Plan, provide the name of the Employer and Insurance Company:
________________________________________________________________________________________
________________________________________________________________________________________

I certify that the above information is correct and that the person is eligible for benefits. I have received the medication described within and authorize release of all information contained on this voucher to Catamaran and the underwriter.

SUBSCRIBER SIGNATURE: __________________________________________________________________________________________