DIRECT MEMBER REIMBURSEMENT FORM

Please attach a detailed receipt from the pharmacy, including all of the following information. If this information is not on the receipt, please have the pharmacist complete and sign this form and attach proof of payment. **Without the required information Catalyst Rx will not be able to process your claim.**

<table>
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<tr>
<th>RX #</th>
<th>Pharmacy NABP/NPI #</th>
<th>Fill Date</th>
<th>Drug Name <em>(including strength)</em></th>
<th>NDC Number</th>
<th>Physician DEA/NPI #</th>
<th>Quantity</th>
<th>Days Supply</th>
<th>Amount Paid</th>
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**PHARMACIST SIGNATURE:**

**PHARMACY PHONE NUMBER:** ________________

*PHARMACIST SIGNATURE IS REQUIRED WHEN A DETAILED RECEIPT IS NOT PROVIDED.*

All reimbursements are subject to plan terms and conditions and may be reduced from the submitted amounts based on plan cost and copayments. Any reimbursement due will be refunded to the policy holder.

Please check one of the following reimbursement request reasons:

- [ ] Member did not have the Catalyst Rx prescription drug card with them.
- [ ] Member did not receive the Catalyst Rx prescription drug card before the time of purchase.
- [ ] Vacation supply
- [ ] Claim was rejected at the pharmacy.
- [ ] Claim consideration for Coordination of Benefits (secondary coverage).
- [ ] Out of network purchase.
- [ ] Other; Please attach a detailed explanation to be considered for reimbursement.

**Fax to:**
1-888-341-8583

**Mail to:**
Catalyst Rx
Direct Member Reimbursement
PO Box 1069
Rockville, MD 20849-1069

6/1/2010