GLOBAL PHARMACEUTICAL BENEFITS, LLC

PRESCRIPTION REIMBURSEMENT FORM

Return Form To: Global Pharmaceutical Benefits, LLC, One Gateway Center, Suite 2600, Newark, NJ 07102

Member Group Name:

TO BE COMPLETED BY MEMBER: Group # _____ (Copy From Prescription Card) Member # _____ (Copy From Prescription Card)

Member Name (First) _____ (Last) _____

Address _____

City _____ State _____ Zip _____ Date of Birth _____

Phone # 's _____

Home Cell Work

TO BE COMPLETED BY PATIENT

Patients Name (First) _____ (Last) _____

Date of Birth Month ( ) Day ( ) Year ( ) Gender M ☐ F ☐

RX #	RX / Dispense Date	New ☐	Refill ☐	DAW

Name of Drug & Strength	Metric Quantity	Days Supply

National Drug Code (NDC)

Total Rx Cost $ _____

Doctor Name: _____

Doctor Telephone #: _____

TO BE COMPLETED BY PATIENT

Patients Name (First) _____ (Last) _____

Date of Birth Month ( ) Day ( ) Year ( ) Gender M ☐ F ☐

RX #	RX / Dispense Date	New ☐	Refill ☐	DAW

Name of Drug & Strength	Metric Quantity	Days Supply

National Drug Code (NDC)

Total Rx Cost $ _____

Doctor Name: _____

Doctor Telephone #: _____

PLEASE NOTE: In order for your prescription to be processed the following is required:

Amount Paid **Date Filled** **Name of Medication** **RX #**
Metric Quantity **Days Supply** **National Drug Code (NDC)**

Note: Itemized Prescription receipts must be attached.