GLOBAL PHARMACEUTICAL BENEFITS, LLC

PRESCRIPTION REIMBURSEMENT FORM

Return Form To: Global Pharmaceutical Benefits, LLC, 1370 Broadway, Room 512, New York, NY 10018

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

Note: Itemized Prescription receipts must be attached.

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	Metric Quantity	Days Supply

Name of Drug & Strength

National Drug Code (NDC)

Total Rx Cost $ _____

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	Metric Quantity	Days Supply

Name of Drug & Strength

National Drug Code (NDC)

Total Rx Cost $ _____

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)**