Member Prescription Reimbursement Claim Form

MEMBER SECTION Please submit one form for each individual patient.

Member Name: _____

Member Address: _____

City: _____, Puerto Rico Zip: _____ - _____

Birth Date: _____ - _____ - _____ Sex: ___ Male ____ Female

Patient ID: _____ (9 digit ID - copy exactly from MMM ID card)

Request Reason (i.e. traveling, etc.):_____

PHARMACY SECTION: Incomplete information may delay processing or may cause form to be returned.

Pharmacy Name or NABP	# Rx	Fill Date	Total Paid	Quantity	Days Supply	Drug Strength or NDC	Prescriber Name	DAW Code

Member's Signature: _____ Date: _____

Mail to:
Medicare y Mucho Más
Pharmacy Department
PO Box 71114
San Juan, PR 00936-8014

Don't forget to attach the original prescription receipt and the cash register receipt to this form.
Reimbursement is based on your Plan's maximum benefit.
Questions concerning this form, call 1-866-333-5470.