Prescription Drug Claim Form

Foreign Claim–Direct Member Reimbursement

NAVITUS
PHARMACY BENEFITS REINVENTED™

Use this form for prescriptions purchased outside of the United States. Reimbursement will be made to the contract holder's address on file.

Part 1: Patient Information

1. Complete all information. Your DMBA ID is on your member ID card.
2. Submit claims within the filing period specified by your benefit plan. If you have questions about your filing period, please call the Navitus Customer Care number on your member ID card.
3. Please submit a separate form for each patient for which you purchased medication.

First name		Last name	MI
Country code	Telephone number	Date of birth	Gender ☐ Male ☐ Female
DMBA ID		Rx PCN	
Contract holder's address			
City		State/province	Postal code
Country			
Member signature			Date signed

Part 2: Pharmacy Information

1. Complete all information.
2. Please submit a separate form for each pharmacy from which you purchased medications.

Pharmacy name			
Street address			
City	State/province	Postal code	Country

Part 3: Receipt Information

1. Include original pharmacy receipt or printout. Cash register receipts must have pharmacy detail. Attach original pharmacy receipt to this form.
2. Receipt must contain the information in the following table. If your receipt is missing any of this information, please ask your pharmacist to provide it.
3. Please provide the explanation of benefits (EOB) or denial letter from the primary insurance carrier if you have primary coverage with another insurance carrier.
4. An incomplete form may be denied, delayed, or returned.
5. Receipts will not be returned; remember to keep a copy of the completed claim form and receipt for your records.

Rx date written	Rx date filled	Medication name and strength (original language)
Rx number	Medication name and strength (English)	
Diagnosis description (condition the medication was prescribed to treat)		
Country medication was prescribed in	Quantity	Number of days' supply
Prescribing physician's first and last name or clinic name		
Currency	Cost	
Amount in U.S. dollars	Exchange rate on purchase date	

Part 4: Direct Deposit

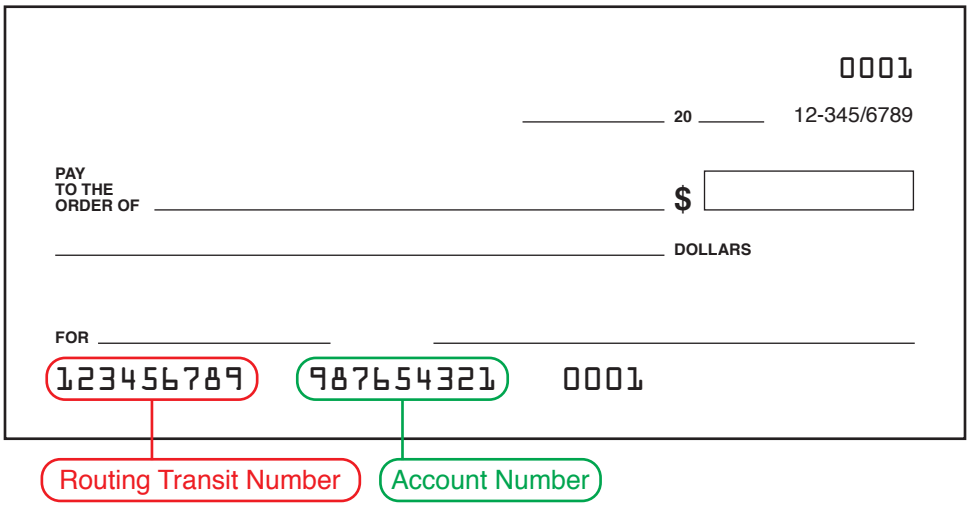
1. Reimbursement for this claim will be mailed to the address in our system unless you prefer direct deposit.
2. For direct deposit, please check the box below and complete all information in this section (do not attach a check).
3. We require direct deposit information for each claim form you submit.

☐ I would like to receive claims reimbursement via direct deposit.

Institution name, city, and state _____

Institution routing transit number _____

Account number _____



Mail this form and receipt to

Navitus Health Solutions, LLC
P.O. Box 999
Appleton, WI 54912-0999

OR

Fax this form and receipt to 920-735-5315 or 855-668-8550

OR

Email the form to claims.team@navitus.com
IMPORTANT NOTE: Email is not secure nor encrypted

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