MC-Rx
Powered by ProCare Rx

Better Health. Within Reach. Every Day.

Request for Drug Reimbursement

PLEASE CHECK YOUR INFORMATION BEFORE SENDING YOUR REQUEST FOR DRUG REIMBURSEMENT TO MC-Rx

Insured Information - Include the name and contract number of the insured who used the pharmacy services as they appear on the pharmacy benefit's identification card provided by MC-Rx or the insurance company. Also include the address clearly and completely, date of birth (month/day/year) and sex.

Insured Signature – The signature of the insured that used the services is required in each request for reimbursement.

Documents required with this form – Include copy of the prescription claimed for reimbursement and the original receipt of payment showing name, address and telephone number of the pharmacy, prescription number, drug name, NDC, prescriber, quantity dispensed, and amount paid for each drug.

Please:

- ✓ Include one (1) pharmacy per request.
- ✓ Include one (1) insured per request.
- ✓ Include up to three (3) drugs per request.

To avoid delays in processing the claim, it is important to complete the form clearly and accurately. If any information is missing, your claim will not be processed. Once completed, send it with the required documents to the following address:

MC-Rx
Call Box 4908
Caguas, Puerto Rico 00726

Attention: Customer Service Center

For your protection, state law requires that the following statement appears on this drug reimbursement request: Any person with knowledge and with intent to defraud, who submits an application to an insurance company or files a claim containing false information or conceals information for the purpose of misleading information concerning any material fact, will incur in a fraudulent insurance act, which is a felony subject to both civil and criminal penalties.

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Important: To process this request for drug reimbursement is necessary to fulfill this formulary. If any information is missing, your claim will not be processed. Enter your name and contract number as they appear in the pharmacy Id card provided by MC-Rx or the insurance company. Be sure to attach copy of the prescription and the original receipt of payment of the drugs. **Once completed the form, send it to: MC-Rx Customer Service Center, Call Box 4908, Caguas, Puerto Rico 00726.**

INSURED INFORMATION (PATIENT)

Last Name		**First Name**	**Initial**
Insured Contract Number (Patient)			
☐ **Mainholder** ☐ **Spouse** ☐ **Dependent**		**Sex**	☐ **Female** ☐ **Male**
Date of Birth (mm/dd/yy)		**Phone Number**	
Postal Address			
City		**State**	**Zip Code** -
Employer Name			

I certify the information above is correct and that I have received drugs that are claimed for reimbursement in this application.

Insured Signature	**X**

PHARMACY INFORMATION

Pharmacy Name	

INFORMATION OF DRUGS

(List up to three (3) drugs per request.)

Date of Service (mm/dd/yy)	/ /	**Rx Number**	
Drug Name		**NDC**	
Quantity Dispensed		**Amount Paid**	$
Prescriber Name			
Explain the reason why the insured had to pay for this drug:			
Date of Service (mm/dd/yy)	/ /	**Rx Number**	
Drug Name		**NDC**	
Quantity Dispensed		**Amount Paid**	$
Prescriber Name			
Explain the reason why the insured had to pay for this drug:			
Date of Service (mm/dd/yy)	/ /	**Rx Number**	
Drug Name		**NDC**	
Quantity Dispensed		**Amount Paid**	$
Prescriber Name			
Explain the reason why the insured had to pay for this drug:			