If you are a member and have a prescription you paid for and need to have processed for reimbursement, print this page, complete the following information and return it to the Prescription Network office. Your request for reimbursement MUST be accompanied by a copy of the prescription claim receipt (NOT a cash register receipt) in order for your claim to be processed:

Employer Group: ____

Cardholder Name: ____

Cardholder ID Number: ____

Patient Name: ____

Address where reimbursement should be sent (reimbursement check will be made out to the Cardholder, regardless of the address you supply):

____

____

Phone Number: ____
(This will only be used in the event we have questions about your claim).

ATTACH A COPY OF THE PRESCRIPTION RECEIPT(S) WHICH YOU ARE REQUESTING REIMBURSEMENT ON.

Submit this completed form, along with your receipt copies to:

Mail: Prescription Network
4125 SW Gage Center Dr, Ste 203
Topeka, KS 66604

Fax: 785-228-9147

If you have any questions, contact the Prescription Network office at 1-800-279-3022.