

224 North Park Ave • Fremont, NE 68025

Phone: (402) 753-2800 • Fax: (888) 810-1394

Reimbursement Request Form

Note: Please send to the attention of the "Reimbursement Department" when mailing this form to Sav-Rx.

Participant Information					
Cardholder Name (See ID Card):					
Cardholder ID (See ID Card):		Relation to Cardholder:	□ Self □	Dependent	
Participant Name:	-	Date of Birth:			
Phone Number:		Email Address:			
Address:	-				
City: Sta	ate:	Zip Code:			
Prescription Information					
Number of Prescriptions Submitted: Da		Date Prescription(s) Filled:			
	-	(For multiple prescriptions please use a range from first to last)			
Out-of-Pocket Total:		Coupon Used At Time Of	Processing:	□ Yes	□ No
Reimbursement Information					
In the space below, please provide the reason for not utilizing the Sav-Rx card/ submitting this reimbursement request:					
Please provide receipts for prescriptions alo	ng with this form.				
Please note any receipts submitted to Sav-Rx for reimbursement must include the following					
Member NameDate of ServiceDrug Name	Quantity DispeAmount PatienDrug NDC		Prescription	Number	
Cardholder Signature			Date		
			- 4.0		