



Date/Time Stamp

**Direct Member Reimbursement
Fax Request**

***MCO must fully complete form and fax to 855-668-8550 (toll-free).
Forms submitted by Texas Medicaid/CHIP members will not be accepted.***

Date:
MCO Name:
MCO Contact Name:
MCO Contact Phone Number:
MCO Contact Fax Number:
MCO Contact Email Address:

Part 1: Member Information

First Name	Last Name	MI
ID Number		

Part 2: Pharmacy Information

Name	
NPI Number	Telephone Number ()

Part 3: Receipt Information

Date Rx Filled	Rx Number	Date Rx Written
Medication Name	National Drug Code (NDC)	
Quantity	Day Supply	
Prescribing Physician First/Last Name		Prescribing Physician NPI (optional)

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Part 4: DMR Refund Amount

Prescription Cost:
Member Copay Amount:
Member Reimbursement Amount:

Part 5: Reason for Request

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Part 6: Refund Check

Provide the following information pertaining to whom the refund check should be addressed:		
Name:		
Street Address:		
City:	State:	Zip:
<i>If Part 6 is not completed, check will be addressed to member and mailed to address shown on eligibility within NCRx.</i>		

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