NAVITUS™
HEALTH SOLUTIONS

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)	

Part 4: DMR Refund Amount

Prescription Cost:

Member Copay Amount:

Member Reimbursement Amount:

Part 5: Reason for Request

Part 6: Refund Check

Provide the following information pertaining to whom the refund check should be addressed:

Name:

Street Address:

City: State: Zip:

If Part 6 is not completed, check will be addressed to member and mailed to address shown on eligbility within NCRx.