

GS-POPS/RESTAT PRESCRIPTION DRUG CLAIM FORM

Please read carefully Before Completing This Form

These claim forms should only be used:

1. During the period between the effective date of your prescription plan and the receipt of your prescription card, if a participating pharmacy is not available (e.g. out of state travel) and a non-participating pharmacy is used.
2. When prescription drugs are purchased at a non-participating pharmacy. (This should not occur on a regular basis).
3. When traveling out of town without your prescription card and reimbursement is needed for prescription drug purchase.

Until your prescription card arrives:

1. COMPLETED CLAIM FORMS MUST BE SENT UNTIL YOU HAVE RECEIVED YOUR PRESCRIPTION CARD. This ensures that the cardholder's name has been recorded by RESTAT as being eligible for the benefit. After your card arrives, this form is to be used only if a participating pharmacy is not available and a non-participating pharmacy is used.
2. You must complete a separate claim form for EACH FAMILY MEMBER and EACH PHARMACY PATRONIZED.
3. Claimant must complete top portion; pharmacist; the lower portion. Claim form must be completed in full or it will be returned to claimant for completion.
4. Obtain claim forms from your employer and mail them directly to the address printed below.

When filing out the claim form indicate the:

1. Insured's Social Security Number. This number is present on the prescription card and can be found above the insured's name.
2. Patient Code – usually a two-digit number. This number is usually indicated before each name on your prescription card. (For example; 01 John; 02 Jane; 03 Jimmy; etc.)

If you have any questions, please call RESTAT Customer Service at (800) 248-1062 or GS-POPS at (800) 633-0037

**FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL**



**RESTAT  
PATIENT REIMBURSEMENT  
P.O. BOX 758  
WEST BEND, WISCONSIN 53095-0758**

Please read reverse side before completing this form:

**YOUR CLAIM CAN NOT BE PROCESSED UNLESS THIS FORM IS COMPLETE**

Plan Administrator: **GSPO Provider Service Corporation (GS-POPS)**

Employer/Company Name: \_\_\_\_\_

Insured's Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_

Insured's Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Phone Number: (Home) \_\_\_\_\_ Business \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_\_ Patient Code: \_\_\_\_\_

Patient Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Relationship to Insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Son \_\_\_\_\_ Daughter \_\_\_\_\_

Is the medication covered under any other group insurance plan? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, Who? \_\_\_\_\_

I certify that the above information is correct and that the above checked person is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this voucher to GS-POPS and/or RESTAT.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

Insured Signature: \_\_\_\_\_

Please ask your pharmacist to complete the remaining portion. Your claim can not be processed unless this form is complete. (You may attach a pharmacy computer print out of the prescriptions, which must include all information indicated below.)

Rx Number \_\_\_\_\_ Date Filled \_\_\_\_\_ Quantity \_\_\_\_\_ Days Supply \_\_\_\_\_ Rx Price \_\_\_\_\_

Medication Name \_\_\_\_\_ Dosage Form \_\_\_\_\_ Strength \_\_\_\_\_

NDC No. \_\_\_\_\_ Doctor's DEA# \_\_\_\_\_ Doctor's Name \_\_\_\_\_

Rx Number \_\_\_\_\_ Date Filled \_\_\_\_\_ Quantity \_\_\_\_\_ Days Supply \_\_\_\_\_ Rx Price \_\_\_\_\_

Medication Name \_\_\_\_\_ Dosage Form \_\_\_\_\_ Strength \_\_\_\_\_

NDC No. \_\_\_\_\_ Doctor's DEA# \_\_\_\_\_ Doctor's Name \_\_\_\_\_

Rx Number \_\_\_\_\_ Date Filled \_\_\_\_\_ Quantity \_\_\_\_\_ Days Supply \_\_\_\_\_ Rx Price \_\_\_\_\_

Medication Name \_\_\_\_\_ Dosage Form \_\_\_\_\_ Strength \_\_\_\_\_

NDC No. \_\_\_\_\_ Doctor's DEA# \_\_\_\_\_ Doctor's Name \_\_\_\_\_

Rx Number \_\_\_\_\_ Date Filled \_\_\_\_\_ Quantity \_\_\_\_\_ Days Supply \_\_\_\_\_ Rx Price \_\_\_\_\_

Medication Name \_\_\_\_\_ Dosage Form \_\_\_\_\_ Strength \_\_\_\_\_

NDC No. \_\_\_\_\_ Doctor's DEA# \_\_\_\_\_ Doctor's Name \_\_\_\_\_

**PLACE PHARMACY LABEL HERE OR ENTER**

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
NABP#