



Immediate Pharmaceutical Services, Inc.

**DIRECT REIMBURSEMENT CLAIM FORM
(PLEASE PRINT)**

PART ONE: To be completed by YOU

[Empty box for Patient Name]

PATIENT NAME

[Empty box for Patient Birthdate]

PATIENT BIRTHDATE

[Empty box for Employee Name]

EMPLOYEE NAME

[Empty box for Employee's Company]

EMPLOYEE'S COMPANY

[Empty box for Employee Social Security Number]

EMPLOYEE SOCIAL SECURITY NUMBER

COBRA

[Empty box for Street Address]

STREET ADDRESS

PATIENT IS:

Male Employee

[Empty box for City]

CITY

Female Spouse

[Empty box for State]

STATE

[Empty box for ZIP]

ZIP

Eligible Child

[Empty box for Phone]

PHONE

Other (Explain)

[Empty box for Signature of Patient, Guardian or Legal Representative]

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

*****PLEASE COMPLETE REVERSE SIDE OF THIS FORM FOR ALLERGY SERUM REIMBURSEMENT*****

PART TWO: Pharmacy Information

[Empty box for Pharmacy NABP Number]

PHARMACY NABP NUMBER

[Empty box for Pharmacy Name]

PHARMACY NAME

[Empty box for Pharmacy Address, City, State, and ZIP]

ADDRESS, CITY, STATE, AND ZIP

I hereby certify by my signature below that the charge(s) shown for the medications prescribed are true and correct.

I agree to provide IPS or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law.

I further recognize that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

[Empty box for Signature of Pharmacist or Pharmacy Representative]

SIGNATURE OF PHARMACIST OR PHARMACY REPRESENTATIVE

[Empty box for Pharmacy Telephone Number]

PHARMACY TELEPHONE NUMBER

Please attach computer receipt for each prescription claimed.

Receipt should contain the following information:

- Date Rx Filled
- Name and Address of Pharmacy
- NDC Number
- Name and Strength of Drug
- Quantity
- Days Supply
- Rx Number
- Price

Please mail completed claim form and receipt(s) to:

Immediate Pharmaceutical Services, Inc.
P.O. Box 166
Avon Lake, OH 44012
Telephone# 1-800-233-3872

Administrators: Klais & Company, Inc.

*PLEASE ALLOW 4 TO 6 WEEKS PROCESSING
TIME UPON IPS' RECEIPT OF THIS CLAIM.*

PHYSICIAN INFORMATION

PHYSICIAN NAME

TELEPHONE NUMBER

ADDRESS

CITY, STATE, ZIP

ALLERGY INFORMATION – Physician please complete information

**Rx
1**

Date filled

Metric quantity of serum

Days Supply

OV Code

List of Antigens

NDC (if available)

Physician ID number

\$\$

Cost of serum

**Rx
2**

Date filled

Metric quantity of serum

Days Supply

OV Code

List of Antigens

NDC (if available)

Physician ID number

\$\$

Cost of serum

**Rx
3**

Date filled

Metric quantity of serum

Days Supply

OV Code

List of Antigens

NDC (if available)

Physician ID number

\$\$

Cost of serum

**Rx
4**

Date filled

Metric quantity of serum

Days Supply

OV Code

List of Antigens

NDC (if available)

Physician ID number

\$\$

Cost of serum

I hereby certify that the charge(s) shown for the medications prescribed is/are correct, and agree to provide IPS or its agents reasonable access to records related to medication(s) dispensed for this patient, in accordance with applicable law. I further recognize that reimbursement will be paid directly to the member and any assignment of these benefits to a physician or otherwise is void. PHYSICIAN SIGNATURE: _____