US-19542-NONBRANDED
Diabetes Mail Order Form PDF

Dimensions: 8.5" w X 11" h

Patient Mail-In Form

INSTRUCTIONS

To receive your reimbursement payment check within 6 to 8 weeks for a valid prescription claim, please complete the following steps:

1. Fill a prescription at your mail-order pharmacy.
2. Print, fill out, and sign this form.
3. Mail this form along with the original Mail-Order Pharmacy Receipt that you received for your prescription (cash register receipts are not acceptable). Forms submitted without these items will not be valid and therefore will not be eligible for reimbursement.

THE MAIL-ORDER PHARMACY RECEIPT SHOULD INCLUDE:

- Patient name and address
- Prescription number or Rx number, fill date, drug name, strength and NDC number
- Quantity, price and/or co-pay amount paid
- Mail-order pharmacy name, address and phone number

FOR MAIL-ORDER PHARMACY PRESCRIPTIONS ONLY

Provide the information below to receive your refund

Patient Name ______________________ Date of Birth (mm/dd/yy) ______________

Address ____

City ______________________ State ______ Zip ____________

Phone ______________ E-mail (optional) ______________________

Drug Name ______________________

Savings Card Group # ☐☐☐☐☐☐☐☐☐☐

Savings Card ID # ☐☐☐☐☐☐☐☐☐☐☐☐

I, ______________________________, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the co-payment or out-of-pocket expenses requested for reimbursement were actually incurred.

I, ______________________________, certify that my prescription was not purchased under a state or federally funded presciption insurance program, including Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DOD) programs, or Tricare, that I am not Medicare eligible and enrolled in an employer – sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Refer to the product prescription savings card program for complete terms and conditions.

Patient Signature ______________________________ Date ______________

Mail your completed form and original Mail-Order Pharmacy receipt to:

AstraZeneca Claims Processing Dept, PO Box 2355, Morristown, NJ 07962

If you have any questions regarding the offer, please call 1-800-236-9933. AstraZeneca reserves the right to change or discontinue prescription program savings offers at any time without notice.

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