



# HAWAII ELECTRICIANS HEALTH & WELFARE FUND

1935 HAU STREET, ROOM 300 • HONOLULU, HAWAII 96819-5003 • PHONE (808) 841-6169 • FAX 847-4596  
NEIGHBOR ISLANDS (TOLL FREE) 800-622-3830

## PHARMACY DIRECT MEMBER REIMBURSEMENT CLAIM FORM

**Claims must be filed within 90 days of date purchased. Use a separate form for each patient.**

Please attach a detailed receipt from the pharmacy, including all of the following information. If this information is not on the receipt, please have the pharmacist complete and sign this form and attach proof of payment. **Without the required information Catalyst RX will not be able to process your claim.**

<b>PRESCRIPTION FILLED FOR:</b>	<b>EMPLOYEE ID NUMBER:</b>
<b>STREET ADDRESS:</b>	<b>DEPENDANT CODE:</b>
<b>CITY, STATE, ZIP:</b>	<b>EMPLOYER NAME: HAWAII ELECTRICIANS HEALTH &amp; WELFARE FUND</b>
<b>EMPLOYEE SIGNATURE:</b>	<b>DATE:</b>

RX #	Fill Date	Drug Name	NDC Number	Prescribing Physician/DEA #	Qty	Days Supply	Amount Paid

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

PHARMACIST SIGNATURE: \_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_

**PHARMACIST SIGNATURE IS REQUIRED WHEN A DETAILED RECEIPT IS NOT PROVIDED.**

**All reimbursements are subject to plan terms and conditions and may be reduced from the submitted amounts based on plan cost and co-payments.**

Please check one of the following reimbursement request reasons:

- Member did not have the Catalyst RX prescription drug card with them.
- Member did not receive the Catalyst RX prescription drug card before the time of purchase.
- Vacation supply
- Claim was rejected at the pharmacy.
- Claim consideration for C.O.B. (secondary coverage)
- Out of network purchase.
- Other; Please attach a detailed explanation to be considered for reimbursement.

