MCS Life Insurance Company

PRESCRIPTION REIMBURSEMENT CLAIM FORM

In order to process a reimbursement for pharmacy services, you need to fill out the following information:

SUSCRIBER'S NAME:	PHONE NUMBER:
SUBSCRIBER'S CONTRACT NUMBER (Printed on plan ID card):	
POSTAL ADDRESS:	
EMPLOYER'S NAME:	

I hereby certify that I (or my eligible direct dependent younger than 21 years old) have (has) received the drug described herein and that the aforementioned plan participant is eligible to receive prescription drug benefits. I also certify that the drug received is not intended to cure a work-related injury and is not covered by any other benefit plan. In case of a dependent 21 years old or older, that dependent subscribes the claim form and certifies the information in it.

I hereby certify that I have read or have been read the information contained in this reimbursement application, and that it is true and correct. I authorize any physician, hospital, pharmacy or other medical or pharmacy service facility, insurance company or other institution to provide the information that MCS requires to analyze this application.

Antifraud Information: According to the dispositions of Law Number 230 of August 9, 2008, created to amend the Insurance Code of Puerto Rico, we inform you that Article 27.250 from the Insurance Code of Puerto Rico orders the following: "Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($ 5,000) and not more than ten thousand dollars ($ 10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years."

_____ _____

Subscriber's signature (required) Date

_____ _____

Legal guardian's signature (required, if applicable) Date

Relationship_____

All reimbursements are subject to the plan's terms and conditions and may be lower than the amount filed based on the cost of the plan and the copayments.

Services rendered in the United States of America:
Claim forms shall be accepted for the payment process along with a detailed receipt that includes: the prescription number, the name of the drug, the amount sold, and the amount paid, per drug. Please make sure you receive a receipt with all the information needed to avoid delays.

Please select one of the following reimbursement request reasons:

- Subscriber did not have the plan ID card.
- Supply for vacation

- Claim was rejected at the pharmacy.
- Out of network purchase
- Claim consideration for Coordination of Benefits (COB). Please write down the information of secondary plan*:*

Insurance Company	Number of Policy or Contract

- Other (Detail)

_____

_____

_____

Attach the official receipt from the pharmacy to this form. If the following information is not included in the receipt, request that the pharmacist fill, sign, and attach the payment receipt to it. Without the required information, {Pharmpix} will not be able to process your claim.

Prescription Number	Pharmacy's NPI Number[1]	Filling Date	Drug name and dose	NDC number[2]	DEA number[3] of the prescribing physician	Amount	Supply days	Total Paid

Pharmacist's signature: _____Pharmacy's telephone number: _____

If detailed receipt not provided, the pharmacist's signature is required in the form.

Instructions for Compound Prescriptions (For pharmacist's use): in case of a compound prescription, write down the NDC number of the costliest ingredient of the drug used in the prescription.

Compound prescriptions (mixtures) - (for pharmacy use only)

NDC number	Name of the ingredient	Amount	Charges

Please return the Prescription Reimbursement Claim Form duly completed, along with your receipts, to:

Address: PharmPix Corp.
2 Street 1 Ste. 500
Guaynabo PR 00968

Fax: 1-(866) 912-2961

This communication contains information which may be considered privileged and confidential and is solely for the use of the intended recipient. If you are not the intended recipient, any review, disclosure, copying, distribution, or use of the contents of this message is strictly prohibited. If you have received this in error, please destroy it and notify MCS immediately at (787) 758-2500.

[1] NPI – National Provider Indicator

[2] NDC – National Drug Code

[3] DEA-Physician Drug Enforcement Administration Number