

Date: _____

Please fill out the following information and return to us as indicated below.

A. Member Information

Cardholder Name:		Cardholder ID #:
Cardholder Phone #:	Plan Name:	Group #:

B. Reason for Reimbursement

Compound Medication

COBRA Request

No ID Card

Eligibility Data Error

Other, please explain:

C. Reimbursement Mailing Instructions

Address:	City:	State:	Zip:
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D. Prescription Information

Date of Service	Prescription #	Medications

When complete, please return this document, along with the pharmacy register receipt and prescription label to:

Mail:

EHIM, Powered by ProCare Rx
ATTN: Prescription Reimbursement Department
26711 Northwestern Highway, Suite 500
Southfield, MI 48033

OR

Fax:

248-948-9904

Email:rxreimbursements@ehimrx.com**FOR INTERNAL USE ONLY**

Reimbursement Amount: \$

Notes: