SAV-RX

224 North Park Ave. Fremont, NE 68025 Phone: 800-228-3108 Fax: 888-810-1394

REIMBURSEMENT REQUEST

PATIENT INFORMATION

Cardholder Name ____**Telephone (___)** _____________

Cardholder ID # ____ **Group #** ____________________

Address ____

City ____**State** ________ **Zip** _________________

Patient Name ____ **DOB** ______________________

Date(s) prescription filled ____

# of Prescriptions Submitted for Reimbursement _______________

Reason for not using the Sav-Rx card ____

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Cardholder Signature

Attach receipt(s) below.

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