OpusHealth™ my.DebitRX.com Tel: 1-800-364-4767

Complete this form and submit with the required receipts to be considered for reimbursement.

Patient Information

Name (Last, First): _____, _____ **Address** (Street): _____

Apt./Suite No. _____ **City:** _____ **State:** ☐☐ **ZIP:** ☐☐☐☐☐

Email: _____ **Phone:** ( ) _____ - _____
(Your email address will be used ONLY for claim status notification. It will be kept confidential and NOT provided to any other party.)

Select the category that best describes your condition: **Date of Birth:** ☐☐/☐☐/☐☐☐☐

☐ Rheumatology ☐ Dermatology ☐ Gastroenterology

Pharmacy Documents

Failure to include any of the following will result in claim rejection:

1. The original pharmacy receipt received from your pharmacy with your Rx (see sample receipt, right) which must include the following information:
   - ✓ Patient name and address
   - ✓ Pharmacy name, address, and phone
   - ✓ Doctor or health care provider name, address, and phone number
   - ✓ Prescription # (Rx #), fill date, drug name, strength, NDC #, and quantity
   - ✓ Overall prescription price and Co-pay amount/out-of-pocket expense paid
2. A receipt (register, pharmacy, explanation of benefits, or other) that clearly identifies the amount paid for this prescription


RECEIPT
OPUS-ISM PHARMACY
1324-106 MOTOR PARKWAY
HAUPPAUGE, NY 11749
Rx:100053 Filled:03/31/05
SMITH, JOHN Q (CC)
123 MOTORPARK WAY
HAUPPAUGE,NY 11788 ORI
MYDRUG 120 MG
Qty:30 NDC:00000000000
No Refills
NO AUTHORIZATION REQUIRED
DR JONES, TOM
1324 MOTOR PARKWAY, HAUPPAUGE,NY 11788
AA0000000 (631)680-4787
RxPrice: $XXX.XX
THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

Certification Statements

Check each of the boxes below to indicate your agreement with and acknowledgment of each statement. **You must agree to and acknowledge each statement for your claim to be eligible.**

- ☐ The information I have submitted on this form and accompanying this form is complete, correct, and valid.
- ☐ I understand that any benefit will be applied after an initial minimum payment of $5.
- ☐ I am self-insured or have commercial insurance.
- ☐ I am not a participant of Medicare Part D, VA, TriCare, Medicaid, or any similar federal or state program.
- ☐ I understand and accept the terms and conditions below.
- ☐ FSA/HSA/HRA not being used.

Claimant/Patient/Legal Guardian Signature: _____ Date: _____

Claim Submission

Submit completed form and receipts via mail or fax to:

MAILING ADDRESS: **Rebate Processing Department, OPUS Health**
Part of IMS Health
PO Box 4581
Warren, NJ 07059

-OR-

FAX NUMBER: **1-631-822-2893**

Terms & Conditions

In Massachusetts, copay assistance is not available for products with certain generic equivalents (for example, any product with an AB-rated generic equivalent). Available to patients with commercial prescription insurance coverage. Copay assistance program is not available to patients receiving prescription reimbursement under any federal, state or government-funded insurance programs (for example, Medicare (including Part D), Medicare Advantage, Medigap, Medicaid, TRICARE, Department of Defense or Veteran's Affairs programs) or where prohibited by law. If at any time a patient begins receiving prescription drug coverage under any such federal, state or government-funded healthcare program, patient will no longer be able to use the copay assistance program and patient must call 1-800-364-4767 to stop participation. Patients may not seek reimbursement for value received from the copay assistance program from any third-party payers. Offer subject to change or discontinuance without notice. Restrictions, including monthly maximums, may apply. **This is not health insurance.**

Please allow 5 business days after receipt of information to receive rebate.
For assistance completing this form, contact OPUS Health at 1-800-364-4767 and select the *Patients* option.