Avia Partners, Inc.
250 E. Parkcenter Blvd
Boise, ID 83706
(800) 273-9166

PRESCRIPTION REIMBURSEMENT REQUEST FORM

For consideration of a manual prescription claim reimbursement; complete the form below, sign and mail to address above. **Attach receipts showing prescription number, drug name, drug strength, quantity, National Drug Code (NDC number), the amount paid and address of the pharmacy filling the prescription. On each receipt please specify days supply for more efficient processing.** If you do not have a receipt, one must be obtained from the pharmacy before submitting this claim.

1). CARD HOLDER INFORMATION

First Name	Middle I.	Last Name
Card Holder I.D. Number	Address	
City, State, Zip	Phone ( )	
Plan Name (Employer, Group or Organization)		

❑ **Check Here for Change of Address**

2). PATIENT INFORMATION

Relationship to Card Holder
Name
Date of Birth

3). PHARMACY INFORMATION

Pharmacy Name	Phone ( )
Address	City, State, Zip.
☐ Female ☐ Male	

4). REASON FOR MANUAL REIMBURSEMENT REQUEST

(could not locate network pharmacy; could not find my card, etc..)

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5). Please read the following carefully and sign below before mailing to Avia Partners.

I certify that all information on this form is correct and that the patient receiving medication is eligible for Avia Partners prescription benefits. I have received the medication described hereon and authorize release of all information contained on this voucher to Avia Partners. I agree that any benefits received for prescription drugs are not assignable and that any assignment or attempted assignment of benefits therefore shall be void.
I further represent that there has been no assignment of benefits hereunder.

Date_________________________

Patient Signature:__________________________________

Card Holder Signature____
(if patient is a minor)

Note: Please allow 2 to 4 weeks for processing and mailing of manual reimbursement requests.

Mail claims to: Avia Partners – 250 E Parkcenter Blvd Boise, ID 83706