Prescription Drug Claim Form

Foreign Claim – Direct Member Reimbursement

Use this form for prescriptions that were purchased outside of the United States. Reimbursement will be made to the Cardholder, unless otherwise stated. Be sure the address you provide is a secure location for mailing of the check. Costco Wholesale Health Solutions is not responsible for lost or stolen checks.

Part 1: Member Information

1. Complete ALL information. Your ID Number can be located on your member ID card.
2. Submit claims within the filing period specified by your Benefit plan. For questions about your filing period please review your Member handbook or call the Customer Care number on your member ID card.
3. Please submit a separate form for each patient for which you purchased medications.
4. Reimbursement will be made directly to the CARDHOLDER unless otherwise noted.

First Name	Last Name	MI
Telephone Number ( )	Date of Birth	Gender (Circle One) Male Female
ID Number	Subscriber's Employer (PCN)	
Mailing Address		
City	State	ZIP Code
Member Signature		Date Signed

Part 2: Pharmacy Information

1. Complete ALL information.
2. Please submit a separate form for each pharmacy from which you purchased medications.

Name			
Street Address			
City	State	ZIP Code	Country

N3412-1012

Part 3: Receipt Information

1. Include original pharmacy receipt(s) or pharmacy printout(s); Cash Register Receipt(s) without pharmacy detail will not be accepted. Tape original pharmacy receipt(s) to bottom of this page. *Please* DO NOT staple.
2. Receipt(s) must contain the information outlined under Part 3. If your receipt(s) are missing any of this information, have your pharmacist fill in the missing information under Part 3.
3. Please provide the explanation of benefits (EOB) or denial letter from the primary insurance carrier if you have primary coverage with another insurance carrier.
4. An incomplete form may be denied, delayed or returned.
5. Receipts will not be returned, remember to keep a copy of the completed claim form and receipt(s) for your records.

<table>
<tr><td>Rx Written Date</td><td>Date Rx Filled</td><td>Foreign Medication Name & Drug Strength</td></tr>
<tr><td>Rx Number</td><td colspan="2">English Medication Name & Drug Strength</td></tr>
<tr><td>English National Drug Code</td><td colspan="2">Diagnosis Code and Description (Medication was to Treat)</td></tr>
<tr><td>Country Drug was Purchased In</td><td>Quantity</td><td>Day Supply</td></tr>
<tr><td colspan="2">Prescribing Physician First/Last Name</td><td>Prescribing Physician NPI</td></tr>
<tr><td>Amount Paid in US Dollars</td><td colspan="2">Rate of Exchange on Date of Purchase</td></tr>
</table>

Mail this form along with receipts to:
Costco Wholesale Health Solutions
P.O. Box 999
Appleton, WI 54912-0999
OR
Fax this form along with receipt(s) to:
(920)735-5315 / Toll Free (855)668-8550