Manual Claim Form

To submit a claim, please enter the required fields highlighted below and send to support@liviniti.com along with any receipts. For help, please call customer support at 833-925-2770.

MEMBER

First Name:

Last Name:

ID#:

Group:

Sex:

◯ Male ◯ Female

Date of Birth:

/ /

PRIMARY CARDHOLDER

First Name:

Last Name:

Relationship:

◯ Self ◯ Spouse ◯ Dependent

CONTACT INFORMATION

Email:

Address Line 1:

Address Line 2:

Phone:

City:

State:

Zip:

PRESCRIPTION DETAILS (Please be sure to attach receipts when submitting the claim form)

Rx Number:	Quantity:	Day Supply:	Amount Paid:	Claim Date:
			$	/ /
			$	/ /
			$	/ /
			$	/ /

☐ **Disclaimer:** The submission of this Rx Claim form, for you and/or dependents, authorizes the release of all information to the Plan Sponsor, Administrator, and/or Pharmacy Benefit Manager

☐ **Certification:** I certify that the information on this form is correct. I also confirm that the patient, for whom this claim is made, had coverage at the time the claim was incurred.

