

# Manual Claim Form



To submit a claim, please enter the required fields highlighted below and send to [support@liviniti.com](mailto:support@liviniti.com) along with any receipts. Claims can also be submitted online through the Member Center. 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:

## PHARMACY INFORMATION

Pharmacy Name:

Address Line 1:

Address Line 2:

Phone:

City:

State:

Zip:

# Manual Claim Form



**PRESCRIPTION DETAILS (Please be sure to attach receipts when submitting the claim form. The point of sale receipt is required. Additional documentation is appreciated.)**

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

*\*If further prescriptions are needed, please complete an additional form.*

- 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.