Date: _____

Cardholder Name: _____ Cardholder ID#: _____

Cardholder Phone#: _____

Plan Name: _____ Group#: _____

Reason for Reimbursement Request

- ☐ Compound Medication
- ☐ No ID Card
- ☐ Other, Please Explain:
- ☐ COBRA Request
- ☐ Eligibility Data Error

If a reimbursement is issued, please make the check payable to the following address:

Address: _____

City: _____ State: _____ Zip: _____

Date of Service:	Prescription#:	Medications

When complete, please return this document, along with the pharmacy register receipt and prescription label, to:

Mail:

EHIM Prescription Reimbursement Department
26711 Northwestern Highway, Suite 400
Southfield, Michigan 48033

OR

Fax

Fax:
248-948-9904

Email:
rxreimbursements@ehimrx.com

For Internal Use Only

Reimbursement Amount:

Notes: