



Manual Claim Form

To submit a manual claim for review, enter information into the required fields highlighted below. Send the completed manual claim form, with any receipts, to support@liviniti.com. Claims can also be submitted online through the Member Center. For help, call customer support at 800-710-9341.

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 Phone
Address Line 1 Address Line 2
City State Zip

PHARMACY INFORMATION

Pharmacy Name Phone
Address Line 1 Address Line 2
City State Zip

PLEASE NOTE: Be sure to attach receipts when submitting the claim form. Both the point of sale receipt AND completed claim form are required for processing. Additional documentation is appreciated.

PRESCRIPTION DETAILS

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

*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.

PLEASE SIGN AND DATE

Signature _____ Name _____ Date / /
(Please Print)