



True Out of Pocket (TrOOP) Submission Form

Please read carefully and fill out the entire form.

Directions:

1. This form must be completely filled out in order to process your claim(s).
2. Attach all prescription receipt(s) to the back of this form.
3. Prescription receipts must contain all of the following information or they will not be accepted: RX number, date filled, Pharmacy NABP#, drug name with NDC number, strength, quantity, days supply, and amount paid.
4. If you have any questions, please call our Customer Service: **1-800-429-6686**, or **TTY/TDD 1-877-279-0371**
5. The form should be signed by the member and mailed to:

RxAmerica Medicare
Attn: MMA TrOOP Submissions
P.O. Box 22690
Salt Lake City, UT 84122-0690

Member Information • Please Print

Member Name (First, Last)	Member ID Number	Phone	Date of Birth
Street Address		Apt.	
City	State	Zip Code	

Prescription Information

Rx Number	Date Rx Filled	Pharmacy NABP#	Drug Name and NDC Number	Strength	Quantity	Days Supply	Amount You Paid

For Office Use Only							
Entered by: _____		Date: _____		Quality Auditor: _____		Date: _____	
Scanned by: _____				Date: _____			



To access a True Out of Pocket (TrOOP) Submission form on the Internet, go to
www.Meds4Medicare.com

This form is not for Reimbursements

Helpful Hints to Speed Up your Submission

Did you include the following information?

- Member ID number
- Actual pharmacy receipts and/or pharmacy print-outs
- The pharmacy's NABP number
- The quantity and days supply for each prescription
- The drug NDC# (National Drug Code) *Can be found on pharmacy receipt in most cases. If not, ask the pharmacist.
- Print your name and member ID
- Is your correct mailing address printed on the front of this form?

Facts to know

Member submissions take approximately 4 to 6 weeks to process.

Use this form every time you are submitting receipt(s) for TrOOP!

Save time by making copies of this form for future submissions.

The RxAmerica Customer Service Center is open Monday – Friday, 8:00 A.M. – 5:00 P.M (local time).

Customer Service Phone Number: 1-800-429-6686

TTY/TDD 1-877-279-0371

I hereby certify that the accompanying statements, are to the best of my knowledge true, correct and complete. I hereby authorize any Physician or service provided to furnish and disclose all known facts concerning this submission, upon request from the claim administrator.

MEMBER SIGNATURE

DATE