PRESCRIPTION CLAIM FORM

Thank you for choosing us for your prescription coverage. Please use this form when you want to be reimbursed for a prescription medication covered under your prescription benefit for which you have paid out of pocket. Refer to the following guidelines when submitting your request:

- Tape your original receipts in the boxes marked for receipts. **Cash register receipts do not provide enough information and are not acceptable.**
- Complete one form per patient.
- Keep copies of receipts for your records. Original copies will not be returned.
- If you have other insurance that is primary over our coverage, an Explanation of Benefits (EOB) from the primary insurance must be submitted with this claim form. The retail cost of the medication and the amount you paid are required to process secondary claims.
- Sign the completed form at the bottom of the second page and mail to:

  Pharmacy Services
  PO Box 13249 M/S CS02
  Salem, OR 97309-1249

- All correspondence including payments and explanations of benefits will be mailed to the cardholder information on file unless a confidential communication request is on file with our privacy office at the time of processing. To update your mailing information or begin a confidential communication request, contact the customer service number below for more information.
- Contact Customer Service at (888) 437-1508 or refer to your benefit booklet for more information about your benefits.

Prescription Information

IMPORTANT:

All claims must include prescription receipts from the pharmacy containing the following information:

● Pharmacy Name/Address	● Drug Name, Strength, Form and National Drug Code (NDC)	● Quantity and Days Supply
● Patient Name	● Date Filled	● Price
● Prescription Number	● Physician's Identifier (National Provider Identifier)	

* Receipts for compounded medications must include the NDC, form, quantity and price of each ingredient contained in the compound.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Patient Information

Patient Name _____ Patient Date of Birth _____

Patient Plan ID Number _____ Daytime Phone Number _____

Cardholder Name _____ Cardholder Date of Birth _____

Other Coverage Information

Do you have any other prescription coverage? If yes, please provide all of the following information that you will find on the other coverage ID card.

ID number for other insurance _____

Rx Group number for other insurance _____

Rx BIN & Rx PCN for other insurance _____

Name of other insurance _____

Phone number for other insurance _____

Check all that apply:

- ☐ My other coverage is a Medicare Part D plan.
- ☐ My other coverage is a discount card and not other insurance.
- ☐ My other coverage is primary over this plan.
- ☐ My other coverage is secondary to this plan.

IMPORTANT:

If you provided other coverage information and the other coverage is primary to this plan, EOB receipts from the primary insurance must be submitted with this claim.

Please indicate the number of receipts attached _____

I hereby certify that all information given is correct. I further certify that all items were purchased for the above named patient. I understand that it is a crime to knowingly provide false or misleading information and that doing so may result in civil or criminal prosecution.

▶ _____ Signature _____ Date

TAPE ORIGINAL RECEIPT HERE

In date order

Cash register receipts do not provide enough information and are not acceptable.

Keep copies for your records.

Check all that apply:

☐ This prescription was administered during a doctor's visit or hospital stay.

☐ This prescription was filled while living or traveling outside of the United States.

Country _____ Currency Type _____

Medication _____ U.S. Equivalent _____

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