Member Reimbursement Request Form

Step 1: Complete the Patient Information

- Each section must be filled out completely
- A separate form must be used for each patient

Patient Information		
Last Name:	**First Name:**	
ID#:	**Date of Birth:**	**Phone#:**
Address:		
City:	**State:**	**Zip:**
Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

Other Coverage Information			
Does the patient have other prescription coverage?	☐ Yes	☐ No	
If yes, is this plan primary or secondary?	☐ Primary	☐ Secondary	☐ Other
Note: If this plan is secondary, an explanation of benefits from the primary plan is required			

Step 2: Submit Pharmacy Receipts

- A copy of ALL original pharmacy receipts must be included in order to process your claims
- Pharmacy receipts must include the below information:

✓ Date Filled
✓ Patient Name
✓ Patient Date of Birth
✓ Prescription Number
✓ Pharmacy Name
✓ Pharmacy NPI Number
✓ Prescriber Name
✓ National Drug Code
✓ Drug Name & Strength
✓ Quantity Filled
✓ Day Supply
✓ Amount Paid

- If pharmacy receipts are not available, please have your pharmacy representative provide the prescription information and sign the form. Please note, a different form will be required for claims from different pharmacies.

Prescription Information	
Rx #:	**Date Filled:**
Patient Name:	**Patient Date of Birth:**
Drug Name & Strength:	**NDC:**
Quantity:	**Day Supply:**
Pharmacy Name:	**Pharmacy NPI:**
Prescriber Name:	**Amount Paid:**

Prescription Information	
Rx#:	**Date Filled:**
Patient Name:	**Patient Date of Birth:**
Drug Name & Strength:	**NDC:**
Quantity:	**Day Supply:**
Pharmacy Name:	**Pharmacy NPI:**
Prescriber Name:	**Amount Paid**

Step 3: Send Form & Pharmacy Receipts

- Fax forms and receipts to 503-346-8326 or mail the completed form and pharmacy receipts to:

  OHSU PBM Services
  8300 Creekside Place, Suite 100
  Beaverton, OR 97008

- Keep a copy of all documents sent for your own records

Processing Information:

- Allow up to 30 days for processing your reimbursement requests
- Reimbursement of prescriptions is not guaranteed and is subject to plan provisions
- Compound prescription reimbursement requests should be submitted via the Compound Claim Form
- For questions regarding this form or reimbursement processing, please contact 1-833-247-6880

Signature Required
I certify that the information on this form is true and accurate. I certify that the patient on this form has received the prescriptions and is covered by this plan. **Signature:** _____ **Date:** _____ **Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent/ Legal Guardian ☐ Pharmacy Representative