

MEDICARE GOVERNMENT PROGRAMS PRESCRIPTION CLAIM FORM

We are pleased to be your prescription plan. Please use the following guidelines when submitting reimbursement requests for prescriptions.

1. Complete one form per patient.
2. Your reimbursement request must be received no later than 90 days from the date the prescription is filled.
3. Complete the information below.
4. Write your identification number on the top of each page.
5. Tape your original receipts in the boxes marked for receipts. Receipts must include pharmacy name and address, full name of patient, date filled, quantity, physician name, name of medication or item, prescription number, and charge/copayment. **Cash register receipts do not provide enough information.**
6. Retain copies of receipts for your records.
7. If you have other coverage and if we are secondary to the other coverage, receipts or Explanation of Benefits (EOB) from the primary insurance carrier must accompany this claim form. The retail cost of the medication and the amount you paid as a copayment are required to process secondary claims.
8. Sign the completed form where indicated at the bottom of this page and mail to:
Pharmacy Services
P.O. Box 12625 M/S S2P
Salem, OR 97309
9. Contact Customer Service or refer to your Evidence of Coverage for questions or full benefit information.
1 (800) 541-8981
TTY: 1 (800) 382-1003
Hours: 8:00 a.m. - 5:00 p.m. Monday - Friday

Identification Number _____ Patient's Name _____

Patient's Date of Birth _____ Daytime Phone () _____

Mailing Address _____

Is this medication covered under any other group insurance policy? If yes, give name of insurance company and their telephone number, Identification number, Rx Bin number, and Rx PCN number. See your other coverage ID card for this information.

Insurance Company name and telephone number _____

Identification Number _____ Rx Bin# _____ Rx PCN# _____

CERTIFICATION STATEMENT:

I hereby certify that all information given is correct and receipts are attached. I further certify that all items were purchased for the patient named above.

Signature _____

Date _____

ID Number _____

TAPE RECEIPT HERE

In date order

At the time this prescription was filled were you a resident in a long-term facility, such as a nursing home? **Yes** **No**

At the time this prescription was filled were you a resident in an assisted living facility, such as a rest home? **Yes** **No**

Is this prescription considered home infusion therapy? **Yes** **No**

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Please return this form to:

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P.O. Box 12625 M/S S2P
Salem, OR 97309**

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CMS APPROVAL: S5916 PD013 01/2006

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