

MEDICARE 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 (ID) 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. Keep copies of receipts for your records.
7. If you have other insurance that is primary over our coverage, receipts or 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 as a copayment are required to process secondary claims.
8. Sign the completed form at the bottom of this page and mail to:
Pharmacy Services
PO Box 12625 M/S S3P
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 users should call 711.
Hours: 8:00 a.m. to 8:00 p.m., 7 days a week (Oct 15 - Mar 1)
8:00 a.m. to 8:00 p.m., Monday - Friday (Mar 2 - Oct 14)

ID 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, please provide all of the following information that you will find on the other coverage ID card.

Insurance Company name and telephone number _____

ID 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. I understand that it is a crime to knowingly provide false or misleading information and that doing so may result in civic or criminal prosecution.

▶ _____
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

TAPE RECEIPT HERE

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