



Pharmacy 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:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other:
Other Coverage Information			
Does the patient have other prescription coverage?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, is this plan primary or secondary?		<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary <input type="checkbox"/> 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	✓ Pharmacy Name	✓ Drug Name & Strength
✓ Patient Name	✓ Pharmacy NPI Number	✓ Quantity Filled
✓ Patient Date of Birth	✓ Prescriber Name	✓ Day Supply
✓ Prescription Number	✓ National Drug Code	✓ 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