Prescription reimbursement

Samaritan Health Plans

Please call the Pharmacy Services line at **541-768-4550**, toll free **800-832-4580** (TTY **800-735-2900**) if you need assistance with completing this form.

Members will be reimbursed based on the plan's **in-network contracted rate** for prescription drugs, **minus any applicable copay or coinsurance.**

Please note: The amount you paid at the pharmacy (cash price) is often higher than the plan's in-network rate, so your reimbursement may be less than what you paid.

Select plan:

☐ Samaritan Advantage ☐ Samaritan Employer Group ☐ Samaritan Choice

Note: Out-of-pocket payments for **IHN-CCO** pharmacy claims are not reimbursable.

Mail to:
Samaritan Health Plans
PO Box 1310
Corvallis, OR 97339

Fax to: 844-611-3831

Reason for submitting direct member reimbursement:

☐ Missing proof of insurance ☐ Out-of-network pharmacy ☐ Primary coverage ☐ Secondary coverage ☐ Other

If "out-of-network" or "other," please explain: _____

Member information (member to whom the medications were prescribed):

First name: _____ Last name: _____ Member ID: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Date of birth: _____

To Help Us Process Your Reimbursement Faster, Please Include:

- **Member Information:** Full name and member ID number.
- **Proof of Payment:** Original pharmacy receipts and/or pharmacy printouts showing payment.
- **Prescription Details:** For each medication, include:
  - Drug name, strength, and quantity
  - Prescribing provider
  - Number of days' supply
- **Drug Code:** The NDC# (National Drug Code) — usually found on your pharmacy receipt. If not, ask your pharmacist.
- **Compound Prescriptions:** Must include a Universal Claim Form from the dispensing pharmacy.
- **Mailing Address:** Your current and correct mailing address.

Facts about your reimbursement claim:

Processing Time: Please allow 2 to 4 weeks for your reimbursement request to be processed.

Form Use: Use this form each time you submit a claim for a member's reimbursement.

Submission Deadline: Reimbursement requests must be submitted within 365 days (one year) from the date the prescription was filled.

Signature Requirement: This form must be signed by the member who received the prescription. If the member is under 18 years old or has a valid authorized representative (such as a power of attorney or Medicare appointment of representative), that individual may sign on the member's behalf.

Pharmacy information:

Pharmacy name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Prescription information:

Rx#	Date filled:	Drug name and strength:	NDC# (on receipt):	Quantity	# of days' supply:	Amount paid:	Prescriber name:	Prescriber phone:

Read and sign:

I hereby certify that the accompanying statements are, to the best of my knowledge, true, correct and complete. I hereby authorize any physician or service provider to furnish and disclose all known facts concerning this claim upon request from the claim administrator. I will reimburse the fund for any overpayment made to me or on my behalf due to an error on this form.

Signature: _____ Date: _____

NOTE: Form must be signed by member to whom the medications were prescribed. If member is under 18 years old the form may be signed by parent.