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.

Note: Members will be reimbursed based on the plan's in-network contracted rate for prescription drugs minus member copay or coinsurance. The cash price paid at the pharmacy is generally higher than the plan's in-network contracted rate for prescription drugs.

Mail to: Samaritan Health Plans, PO Box 1310, Corvallis, OR 97339 **Fax to:** 844-611-3831

Select plan:

☐ Samaritan Advantage ☐ IHN-CCO ☐ Samaritan Employer Group ☐ Samaritan Choice

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: _____

Including the following information will speed your reimbursement:

- ☑ Member name and ID number.
- ☑ Original pharmacy receipts and/or pharmacy print-outs.
- ☑ Quantity, strength, prescriber and number of days' supply for each prescription.
- ☑ Drug NDC# (National Drug Code) — this can be found on the pharmacy print out receipt in most cases, or ask the pharmacist.
- ☑ Compound prescriptions must include the universal claim form from the dispensing pharmacy.
- ☑ Your correct mailing address.

Facts about your reimbursement claim:

- It takes 2 to 4 weeks to process member reimbursements.
- Use this form every time you are submitting claim(s) for each member's reimbursement.
- Claims must be received within a certain period from the fill date: **Samaritan Advantage:** 365 days (1 year), **IHN-CCO, Employer Group, Choice:** 180 days (6 months).
- Form must be signed by the member for whom the prescriptions were dispensed, unless the member is under 18 years of age or there is a valid authorized representative form, power of attorney or appointment of representative (Medicare).

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.