Prescription Drug Claim Form

PacificSource HEALTH PLANS

Please use this form to submit a claim for covered prescriptions filled by licensed pharmacists. Copies of more than one receipt may be included with this form, but please submit a separate form for each member. The deadline for submitting claims is one year from the date the prescription was filled. (Exception: If your pharmacy claim was processed by another health insurance company, and you recently received a letter from them asking for a reimbursement.)

1. **Complete, sign, and date this form.** Find your group and member ID numbers on your member ID card.
2. **Attach a copy of your pharmacy receipt** (similar to the bottle label). No staples please.
   Attach a copy of the Explanation of Benefits (EOB) statement or printout from the filling pharmacy if you have primary coverage through another health insurance company (double covered). See last section below.*
   Attach a copy of the "request for reimbursement" letter if you received one from another health insurance company that previously processed this prescription claim.
3. **Return this form with attachments to our Claims Department.** Once we receive a claim, it typically takes no more than 30 days to process. If we need more information or if there is a delay, we will contact you.
   Mail: PacificSource Claims Department, PO Box 7088, Springfield OR 97475 or email pharmacy@pacificsource.com.

Please note: Reimbursements are sent to the policy subscriber at the address we have on file.

Questions? Please contact us at **844-877-4803** or pharmacy@pacificsource.com**.** We will be happy to assist you.

Your information

Your last name _____ First name _____ Middle initial _____

Member ID number _____ Birthdate (mm/dd/yyyy) _____

Street address _____ City _____ State _____ Zip _____

Daytime phone _____ Email _____

Claim is for: Last name _____ First name _____ Middle initial _____

Relationship to you: ☐ Self ☐ Spouse or domestic partner ☐ Child

Your signature

I hereby certify that all information is correct.

Your signature _____ Date _____

Pharmacy receipt

Please attach a copy of the pharmacy receipt (not cash register receipt). It is similar to the bottle label and is usually stapled to or in the bag containing your medication. The pharmacy receipt must include:

- Dispensing pharmacy name
- Prescribing doctor/nurse practitioner name
- Date prescription was filled
- NDC (National Drug Code) number
- Medication name and strength
- Quantity of drug dispensed and the number of days it is for (example: #30 /30 days)

*Primary coverage through another health plan (double coverage)

If you have primary coverage through another health insurance company, please include a copy of your Explanation of Benefits (EOB) statement showing what they paid, or a printout from the dispensing pharmacy, with the pharmacy receipt and this form. The Explanation of Benefits statement or pharmacy printout must include:

- Amount paid by primary plan
- Amount you paid (such as copay)
- Total cost of medication

Number of pages attached to this form _____