Prescription reimbursement

Samaritan Health Plans

Please call our 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 co-pay or co-insurance. 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:** 1-844-611-3831

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):			
Last name:	First name:	Member ID:	
Address:	City:	State:	ZIP:
Phone:	Date of Birth:		

Helpful hints to speed up your reimbursement:

Did you include the following information?	**Facts to know:**
✓ 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	• It takes two 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 365 days from date of fill. • 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, POA, 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 accompany statements are, to the best of my knowledge, true, correct and complete. I hereby authorize any Physician or service provided 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 error on this form.

Signature: _____ Date: _____

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