SAMARITAN HEALTH PLANS • 2300 NW WALNUT BLVD • CORVALLIS OR 97339

PRESCRIPTION REIMBURSEMENT

- All areas of this form must be completed and signed. PLEASE PRINT CLEARLY.
- ATTACH ALL PRESCRIPTION RECEIPT(S) PRINT OUT TO THIS FORM.
- PRESCRIPTION RECEIPTS MUST CONTAIN ALL OF THE FOLLOWING INFORMATION or they will not be accepted: RX number, date filled, drug name with NDC number, strength, quantity, days' supply, prescriber information, and amount paid.
- Compound prescriptions must include a Universal Claim Form from the dispensing pharmacy for each compounded medication filled.
- Please call our Pharmacy Services Line at 541-768-4550 or toll free 1-800-832-4580 if you need assistance with completing this form. TTY users should call 1-800-735-2900.
- Members will be reimbursed based on the Plan's in-network contracted rate for prescription drugs minus member co-pay or co-insurance. Note: the cash price paid at the pharmacy is generally higher than the Plan's in-network contracted rate for prescription drugs.
- SIGN FORM AND MAIL TO: Samaritan Health Plans, PO Box 1310, Corvallis, OR 97339

HEALTH PLAN (one only):			
❑ IHN-CCO	❑ Samaritan Advantage	❑ Samaritan Choice	❑ Samaritan Employer Group Plans

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 whom the medications were prescribed):		
Last name:	First name:	Health Plan ID #:
Address:	City, State, Zip:	
Phone:	Date of birth: __ __ / __ __ / __ __ (month/day/year)	

HELPFUL HINTS TO SPEED UP YOUR REIMBURSEMENT:

Did you include the following information?	Facts to know:
✓ Member 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 ✓ Printed member name and member ID ✓ 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. • Make a copy of this form for future reimbursements to save time. • Customer Service is available 8 a.m. to 8 p.m., daily. We are closed on Thanksgiving Day and Christmas Day. • Claims must be received within 365 days from date of fill.

PRESCRIPTION REIMBURSEMENT, *continued*

PHARMACY INFORMATION:								
Name:				Phone:				
Address:				City, State, Zip:				
PRESCRIPTION INFORMATION:								OFFICE USE
Rx#	Date filled	Drug Name and Strength	NDC# (on receipt)	Quantity	# of days' supply	Amount paid	Prescriber Name & Phone Number	Prescriber NPI and Pharmacy NPI

READ AND SIGN THIS:

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.

Member 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.