Select Health

P.O. Box 30196 Salt Lake City, UT 84130-0196 **855-442-9900 (TTY: 711) selecthealth.org/medicare**

Prescription Reimbursement Form

Refer to the second page of this form for additional instructions.

A. Member Information

Member ID# _ _ _ _ _ _ _ _ _ _This number can be found on your member ID card.

Member's Name _____ Date of Birth ____ / ____ / ____

We send any reimbursements and/or communications to the address we have on file unless it has been marked as confidential. If you use a different address than the one we have on file, please provide it below.

Address _____

City _____ State _____ Zip _____

B. Coordination of Benefits (COB) Policy Information

Do you have other insurance? ☐ Yes ☐ No

If yes, and both policies are through Select Health, please list the other Member ID#_____

If yes, and both policies are NOT through Select Health, please complete the following:

Insurance Company _____ Is this your primary insurer? ☐ Yes ☐ No

C. Claim Information

Was the prescription purchased outside of the U.S.? ☐ Yes ☐ No

If yes, do you reside outside the U.S.? ☐ Yes ☐ No

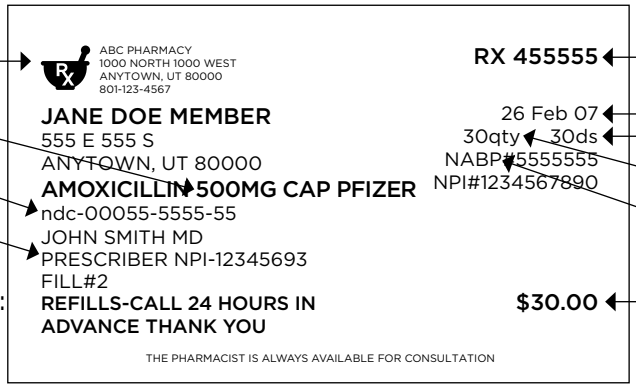
If purchased outside U.S., please indicate Country _____ Currency _____

Was the prescription purchased as the result of an emergency? ☐ Yes ☐ No

D. Prescription Documentation (please see Section E. if this claim is for coordination of benefits)

If Select Health is your only insurance, please enclose a copy of your receipt. Cash register receipts are not acceptable.

The following information is required for each prescription receipt submitted:



The undersigned certifies that the medication(s) identified with this form was/were received by the undersigned for the party named above who is eligible for drug benefits, and that such medications(s) is/are not for an on-the-job injury or covered under another benefit plan or by a prescription assistance program (in full or in part). Participant understands that reimbursement may be subject to Select Health's allowed amounts, minus any applicable deductibles or copay/coinsurance. Reimbursement will be paid directly to the participant, and assignment of these benefits to a pharmacy or otherwise is void.

Signature _____ **Date** ____ / ____ / ____

(Member or Legal Representative)

E. Coordination of Benefits (COB) Prescription Documentation

For COB, ask the pharmacy to send secondary claims directly to Select Health. This allows for easy digital processing. If you forgot to have your pharmacy submit your secondary claim, or they were unable to submit the claim for you, use this form to submit any unpaid amounts to Select Health for possible coverage. Please include a detailed Explanation of Benefits (EOB) from your primary insurance company or a detailed prescription/receipt history from the pharmacy.

Documentation must include the information listed in the above section.

- Pharmacy name
- Pharmacy NABP or NPI number
- Prescription number
- Date of service
- National Drug Code (NDC)
- Quantity dispensed
- Days' supply
- Primary insurance name
- Primary insurance Billing Identification Number (BIN)
- Total amount your primary insurance paid
- Total amount you paid to the pharmacy out of your pocket

Please enclose a copy of the documentation with this form. Without this documentation, Select Health cannot process your secondary insurance claim and reimburse you.

Prescription Reimbursement Form Instructions

Complete all of the information on the front of this form to ensure that your benefits are administered correctly and without delay. Claims must be submitted within **36 months** from the date of service or the date processed by the primary insurer.

If you are submitting multiple receipts, fill out one reimbursement form for each receipt. If you are submitting a printout/report from the pharmacy, only one form per person is required. This information can be obtained from your member ID card and the pharmacy where you purchased your prescription(s).

All claims should be submitted by:

MAIL	EMAIL	FAX
Select Health **Attn: Pharmacy Services** **P.O. Box 30196** **Salt Lake City, Utah 84130-0196**	**SHAWDPharmacy@selecthealth.org**	**801-650-3279**

Claims submitted without the proper identification numbers may be delayed or returned for additional information.

If you have questions, call Pharmacy Services at **855-442-9900** (toll-free) during the following dates and times:

October 1 to March 31: Weekdays: 7:00 a.m. to 8:00 p.m. Saturday and Sunday: 8:00 a.m. to 8:00 p.m.

April 1 to September 30: Weekdays: 7:00 a.m. to 8:00 p.m. Saturday: 9:00 a.m. to 2:00 p.m. Closed Sunday.

Outside of these hours of operation, please leave a message. Your call will be returned within one businessday. TTY users, please call **711**.

Select Health is an HMO, PPO, SNP plan sponsor with a Medicare contract. Enrollment in Select Health Medicare depends on contract renewal.

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats by contacting **Select Health Medicare: 855-442-9900 (TTY: 711)**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電