selecthealth

P.O. Box 30192, Salt Lake City, UT 84130-8212 801-442-5038/800-538-5038 **selecthealth.org**

Prescription Reimbursement Form

Refer to the back of this form for additional instructions. Office Use Only: DMR ❑ COB ❑

A. SUBSCRIBER AND MEMBER INFORMATION

Subscriber ID# __ __ __ __ __ __ __ __ __ This number can be found on your member ID Card.

If this is a claim for coordination of benefits and both subscribers are SelectHealth members, list the other

Subscriber ID# __ __ __ __ __ __ __ __ __

Member's Name _____ Member's Date of Birth _____ (MM/DD/YY)

Relationship to Subscriber ❑ Self ❑ Spouse ❑ Dependent

Check here if there is a different address on file ❑

We will send any reimbursement and/or communications to the address in our system for the member (this is usually the same address as the subscriber) unless a confidential address (e.g., address of a custodial parent) for the member is on file.

B. OTHER INSURANCE INFORMATION

Does the member have other insurance besides SelectHealth? ❑ Yes ❑ No If yes, please complete the following:

Insurance Company _____ Is this the member's 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

The undersigned certifies that the medication(s) identified below was/were received by the undersigned for the party(ies) named above who is/are 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). The undersigned further authorizes use of such person's Social Security number for identification purposes. Reimbursement will be paid directly to the participant, and assignment of these benefits to a pharmacy or otherwise is void.

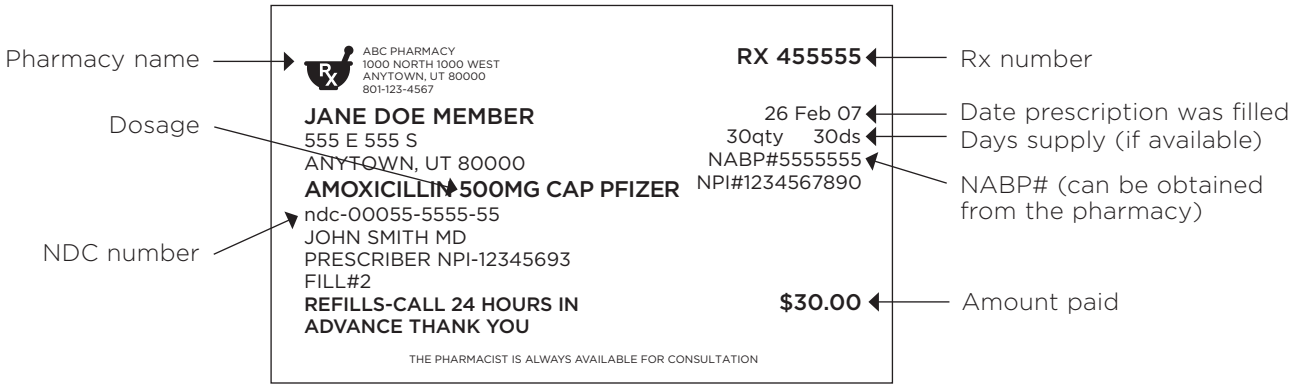
Signature _____ **Daytime Ph#** (_____)_____

(Member, Guardian, or Legal Representative)

D. PHARMACY RECEIPT

Tape one pharmacy receipt in this space. Cash register receipts are not acceptable. Please do not use staples.

The following information is required for each prescription receipt submitted:



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 12 months from the date of service or the date processed by the primary insurer.

If you are submitting receipts for multiple family members, one reimbursement form is required for each person. If you are submitting only for yourself, only one form is necessary.

The information needed can be obtained from your member ID Card and the pharmacy where you purchased your prescription(s).

All claims should be submitted via the following:

MAIL	E-MAIL	FAX
SelectHealth **Attn: Pharmacy Services** **P.O. Box 30192** **Salt Lake City, Utah 84130-0192**	**SHAWDPharmacy@selecthealth.org**	**801-650-3279**

Refer to your ID Card for more information. Call us if you do not have a current ID Card. Claims submitted without the proper identification numbers may be delayed or returned for additional information.

If you have questions, call Member Services at **801-442-5038** (Salt Lake area) or **800-538-5038** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

COORDINATION OF BENEFITS (COB)

If you have additional insurance, you still need to attach the receipt from the pharmacy. If the pharmacy receipts are incomplete, you may also need to obtain an Explanation of Benefits (EOB) from your primary insurer.