Prescription Drug Reimbursement Request Form

Providence Health Plan

Providence Health Plan requires members to use participating pharmacies to access prescription drug benefits. As a member of the Plan, you have access to participating pharmacies nationwide. This Prescription Drug Reimbursement Request form is for use in exceptional circumstances when you are unable to access your prescription drug benefit, (e.g. Emergencies). Benefits are as shown on your Prescription Drug Summary of Benefits and all covered services are subject to the specific conditions, duration limitations and all applicable maximums of the Group Contract on a usual, customary and reasonable (UCR) cost basis. **The submission of this form does not guarantee reimbursement.**

In the area(s) provided below, please explain in detail the reason(s) you did not use your prescription benefit **and** attach any itemized receipt(s). Submit this completed form to: **Providence Health Plans, ATTN: Pharmacy Services, P.O. Box 3125, Portland OR, 97208-3125 or fax 800-249-7714.** Please remember to contact your Customer Service team at one of the numbers listed below if you need future assistance with locating a participating pharmacy.

PATIENT & INSURED (SUBSCRIBER) INFORMATION			
PATIENT NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	PATIENT'S DATE OF BIRTH	PATIENT'S SEX ☐ M ☐ F	MEMBER ID NO.
PATIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)			
INSURED'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)		INSURED'S GROUP NO. (OR GROUP NAME)	
INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			

1) Please provide an itemized receipt which will contain (your pharmacy can provide this information if needed):

- Pharmacy name, address, and phone number
- A prescription number
- Date of service
- National drug code (NDC)
- Quantity dispensed
- Provider name
- Member cost

Reason for not utilizing prescription copayment benefit:

_____
_____
_____
_____
_____
_____

2) Attach itemized receipt(s) suitable for insurance billing purposes here

[ ] [ ]

Attach itemized receipt(s) suitable for insurance billing purposes here

Attach itemized receipt(s) suitable for insurance billing purposes here

[ ] [ ]

PLEASE ATTACH A SEPARATE SHEET IF YOU HAVE MORE ITEMIZED RECEIPTS TO SUBMIT

I hereby certify that all information given is correct. I further certify that all drugs and medicines were prescribed by a physician and were purchased for the family member named.

_____ _____
PATIENT'S SIGNATURE (OR PARENT / LEGAL GUARDIAN) DATE

Customer Service:

- Portland Metro Area: **503-574-7400**
- All Other Areas: **1-877-216-3644**
- TTY (For the Hearing Impaired): **711**