Prescription Drug Reimbursement Request Form

Providence Health Plan
POWERED BY Collective Health

Providence Health Plan Powered by Collective Health 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 Plan, ATTN: Pharmacy Services, P.O. Box 3125, Portland OR, 97208-3125**, or fax 800-249-7714. Need help locating a participating pharmacy? Contact a Member Advocate at 855-526-3824.

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

[ ] [ ]

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

Have questions? Contact a Member Advocate: 855-526-3824