PRESCRIPTION DRUG CLAIM FORM - DIRECT MEMBER REIMBURSEMENT

Use this form for prescription medications that were purchased without using your ID card.
Claim submission is not a guarantee of payment. Reimbursement is subject to plan pharmacy benefits.

Cardholder name:		Cardholder number:	
Cardholder address:			
City:		State:	Zip:
Group number (RxGrp):		Group name (RxPCN):	
Patient date of birth:		Patient gender: ☐ Male ☐ Female	
Send check to:			

Does patient have other drug coverage? ☐ Yes ☐ No

If yes, and other insurance is Medicare, attach a copy of the Medicare Explanation of Benefits (MEOB).

If yes, and other insurance is not Medicare, include denial notification from the primary insurance carrier or pharmacy printout.

PRESCRIPTION/OTHER INSURANCE INFORMATION

This section must be completed by you or your dispensing pharmacist. Prescription receipts or pharmacy printouts must be attached; sales receipts without pharmacy detail will not be accepted. Receipts cannot be returned. Please keep a copy.

#1: **Pharmacy name:**		Address:	
Diagnosis code/description:			
Rx number:	Drug name and strength:		NDC #:
Rx date written:	Date filled:	Quantity:	Days supply:
Physician name:		Physician NPI # (if available):	
Other insurance company name:		Other insurance phone number:	
Original cost of Rx:		Amount primary insurance paid on Rx:	
Patient paid amount:		Vaccine admin fee:	

#2: **Pharmacy name:**		Address:	
Diagnosis code/description:			
Rx number:	Drug name and strength:		NDC#:
Rx date written:	Date filled:	Quantity:	Days supply:
Physician name:		Physician NPI # (if available):	
Other insurance company name:		Other insurance phone number:	
Original cost of rx:		Amount primary insurance paid on rx:	
Patient paid amount:		Vaccine admin fee:	

This claim form can be used to request reimbursement of covered expenses. Please check which reason applies.

- ☐ I did not have my ID card at the time of purchase
- ☐ I was charged for medication received during an urgent/emergent visit
- ☐ I was administered a Medicare Part D covered vaccine in my doctor's office
- ☐ Primary coverage is with another insurance carrier (Coordination of Benefits)
- ☐ A discount was applied at the pharmacy

I certify the above information is correct, and the prescriptions listed above are for me or for eligible members of my family who have received the medication described on this form. I authorize release of all information contained on this claim.

Member Signature Date

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.

MAIL TO
COA/AHC Grievances and Clinical Appeals
PO Box 17950
Denver, CO 80217
Fax: 303-755-4148

Please include all itemized receipts or your request may be delayed.

If you need this document in large print, Braille, other formats, or languages, or read aloud, or need another copy, call 800-511-5010. For TDD/TTY, call 888-803-4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free.

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