PRESCRIPTION DRUG CLAIM FORM - DIRECT MEMBER REIMBURSEMENT

Date received:

Name of person requesting reimbursement:

Phone number: | Name of member:

Complainant relationship with member:

ID number:

Reason for reimbursement:

Date of purchase:

Amount paid:
Note: Reimbursement amount will be equal to amount paid minus any applicable copays

Pharmacy name: | Pharmacy phone number:

Pharmacy address:

Provider Name: | Provider phone number:

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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