AVERA HEALTH PLANS Rx

P.O. Box 30192, Salt Lake City, UT 84130-8212 833-464-7663

Prescription Reimbursement Form

The second page of this form has additional instructions. For faster service, use the online version of this form inside your **Avera Health Plans member account** or on the Member Resources page at **averahealthplans.com**.

A. SUBSCRIBER AND MEMBER INFORMATION

Subscriber ID# _____ (This 10-digit number can be found on your member ID card).

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. COORDINATION OF BENEFITS (COB) POLICY INFORMATION (Please see Section E. if this claim is for coordination of benefits)

Does the member have other prescription coverage? ❑ Yes ❑ No

If yes, and both policies are Avera Health Plans, please list the other Subscriber ID# _____

If yes, and both policies are NOT Avera Health Plans, 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

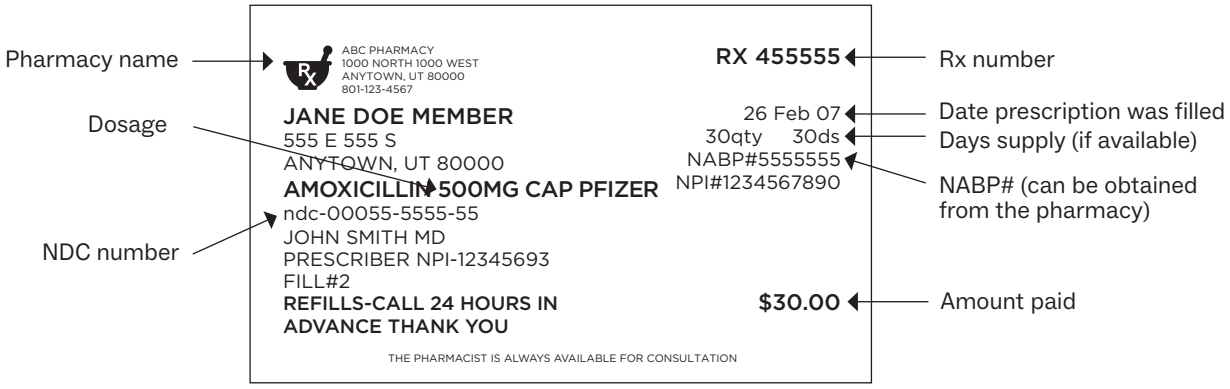
If purchased outside U.S., please indicate Country _____ Currency _____

Was the prescription purchased as the result of an emergency? ❑ Yes ❑ No

D. PRESCRIPTION DOCUMENTATION (Please see Section E. if this claim is for coordination of benefits)

For members with Avera Health Plans as their only insurance, please enclose a copy of your pharmacy receipt. Cash register receipts are not acceptable.

The following information is required for each prescription receipt submitted:



The undersigned certifies that the medication(s) identified with this form was/were received by the undersigned for the party named above who is 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). Participant understands that reimbursement may be subject to Avera Health Plan Rx's allowed amounts, minus any applicable deductibles or copay/coinsurance. 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)

E. COORDINATION OF BENEFITS (COB) PRESCRIPTION DOCUMENTATION

For Coordination of Benefits (COB), **the best option is to ask the pharmacy to submit secondary claims electronically using BIN: 026952 and PCN: AVERA**. If your pharmacy is not able to submit the claim electronically for you, use this form to submit any unpaid amounts for possible coverage. For us to process your claim, you will need to include a detailed Explanation of Benefits (EOB) from your primary insurance company or a detailed prescription receipt/history from your pharmacy. The documentation must include:

- Pharmacy name
- Pharmacy NABP or NPI number
- Prescription number
- Date of service
- National Drug Code (NDC)
- Quantity dispensed
- Days' supply
- Primary insurance name
- Primary insurance Billing Identification Number (BIN)
- Total amount your primary insurance paid
- Total amount you paid to the pharmacy out of your pocket

Please enclose a copy of the documentation with this form. Without this documentation, Avera Health Plans Rx cannot process your secondary insurance claim and reimburse you.

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
Pharmacy Services **P.O. Box 30192** **Salt Lake City, Utah 84130-0192**	**SHAWDPharmacy@selecthealth.org**	**801-442-0770**

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 Pharmacy Services at **833-464-7663** weekdays, from 7:00 a.m. to 8:00 p.m. MT, and Saturdays, from 9:00 a.m. to 3:00 p.m. MT.