MEDICARE GOVERNMENT PROGRAMS
PRESCRIPTION CLAIM FORM

We are pleased to be your prescription plan. Please use the following guidelines when submitting reimbursement requests for prescriptions.

1. Complete one form per patient.
2. Your reimbursement request must be received no later than 90 days from the date the prescription is filled.
3. Complete the information below.
4. Write your identification number on the top of each page.
5. Tape your original receipts in the boxes marked for receipts. Receipts must include pharmacy name and address, full name of patient, date filled, quantity, physician name, name of medication or item, prescription number, and charge/copayment. **Cash register receipts do not provide enough information.**
6. Retain copies of receipts for your records.
7. If you have other coverage and if we are secondary to the other coverage, receipts or Explanation of Benefits (EOB) from the primary insurance carrier must accompany this claim form. The retail cost of the medication and the amount you paid as a copayment are required to process secondary claims.
8. Sign the completed form where indicated at the bottom of this page and mail to:
   Pharmacy Services
   P.O. Box 12625 M/S S4P
   Salem, OR 97309
9. Contact Customer Service or refer to your Evidence of Coverage for questions or full benefit information.
   1 (800) 541-8981
   TTY: 1 (800) 382-1003
   Hours: 8:00 a.m. - 5:00 p.m. Monday - Friday

Identification Number ______________________ Patient's Name ______________________

Patient's Date of Birth ______________________ Daytime Phone (   ) ______________________

Mailing Address ____

Is this medication covered under any other group insurance policy? If yes, give name of insurance company and their telephone number, Identification number, Rx Bin number, and Rx PCN number. See your other coverage ID card for this information.

Insurance Company name and telephone number ______________________________

____

Identification Number ______________________ Rx Bin# ____________ Rx PCN# ____________

CERTIFICATION STATEMENT:

I hereby certify that all information given is correct and receipts are attached. I further certify that all items were purchased for the patient named above. I understand that it is a crime to knowingly provide false or misleading information and that doing so may result in civic or criminal prosecution.

______________________________ ______________________________

Signature Date

ID Number ______________________________

TAPE RECEIPT HERE

In date order

At the time this prescription was filled were you a resident in a long-term facility, such as a nursing home? ☐ **Yes** ☐ **No**

At the time this prescription was filled were you a resident in an assisted living facility, such as a rest home? ☐ **Yes** ☐ **No**

Is this prescription considered home infusion therapy? ☐ **Yes** ☐ **No**

TAPE RECEIPT HERE

In date order

At the time this prescription was filled were you a resident in a long-term facility, such as a nursing home? ☐ **Yes** ☐ **No**

At the time this prescription was filled were you a resident in an assisted living facility, such as a rest home? ☐ **Yes** ☐ **No**

Is this prescription considered home infusion therapy? ☐ **Yes** ☐ **No**

ID Number ______________________________

TAPE RECEIPT HERE

In date order

At the time this prescription was filled were you a resident in a long-term facility, such as a nursing home? ☐ **Yes** ☐ **No**

At the time this prescription was filled were you a resident in an assisted living facility, such as a rest home? ☐ **Yes** ☐ **No**

Is this prescription considered home infusion therapy? ☐ **Yes** ☐ **No**

TAPE RECEIPT HERE

In date order

At the time this prescription was filled were you a resident in a long-term facility, such as a nursing home? ☐ **Yes** ☐ **No**

At the time this prescription was filled were you a resident in an assisted living facility, such as a rest home? ☐ **Yes** ☐ **No**

Is this prescription considered home infusion therapy? ☐ **Yes** ☐ **No**

Please return this form to:

Pharmacy Services
P.O. Box 12625 M/S S4P
Salem, OR 97309

CMS APPROVAL: S5609 PD013 01/2006
CMS APPROVAL: S5916 PD013 01/2006
CMS APPROVAL: PD013 01/2006