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.