**Pharmacy Claim Reimbursement Form**

Usted puede recibir este documento en otro idioma, impreso en letra más grande o de cualquier otra manera que sea mejor para usted. Llame al número gratuito
(800) 431-4135. Los usuarios del servicio TTY pueden llamar al (800) 735-2900*.*

*You can get this letter in another language, large print, or another way that’s best for you. Call (800) 431-4135 TTY (800) 735-2900.*

Please attach proof of payment to completed form. *Please do not include original receipts.*

|  |  |
| --- | --- |
| **A. Member Information** | **Today’s Date:** |
| Name (Last, First, MI): | Member ID Number: | Date of Birth: / / |
| Address: | City: | State: | Zip Code: |
| Please explain why your member card was not used to pay for your medicine: |
|   |
| **B. Pharmacy Information** |
| Pharmacy Name:  |
| Address: |
| Phone: | NPI/NAPB Number: |
| **C. Claim(s) Information** |
| **1.** Is this a compound Rx?: □ Yes □ No  | Fill Date:  | Rx Number: | Quantity: | Day Supply: |
| National Drug Code (NDC): | Drug Name:  | Strength/Dosage: | Total Cost: |
| Prescriber Name: | NPI Number: | Phone Number: |
| **2.** Is this a compound Rx?: □ Yes □ No  | Fill Date:  | Rx Number: | Quantity: | Day Supply: |
| National Drug Code (NDC): | Drug Name  | Strength/Dosage: | Total Cost: |
| Prescriber Name: | NPI Number: | Phone Number: |
| **3.** Is this a compound Rx?: □ Yes □ No   | Fill Date:  | Rx Number: | Quantity: | Day Supply: |
| National Drug Code (NDC): | Drug Name:  | Strength/Dosage: | Total Cost: |
| Prescriber Name: | NPI Number: | Phone Number: |
| **Compounds:****Even if you have itemized receipts, the following must be completed** if the prescriptions being submitted for a refund are compound drugs.  |
| NDC Number | Ingredient | Quantity | Cost |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Compounding Fee |  |  |  |
|  |

I certify that the information on this claim form is correct to the best of my knowledge.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mail completed form and proof of payment to:**

PacificSource Community Solutions

Attn: Pharmacy Services

PO Box 5729

Bend, Oregon 97708-5729

Refund of submitted claims is subject to your prescription benefit. If a refund is allowed, it will be only for the amount your prescription benefit would have paid. The amount of your refund may be lower than the original amount you paid.