**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.*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | | |
|  | |  | | | |  | | | | |  | | |
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|  | |  | | | |  | | | | |  | | |
| 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.