prescription drug reimbursement request form

westernhealth ADVANTAGE

Western Health Advantage requires members to use participating pharmacies to access prescription drug benefits. As a member of the Plan, you have access to participating pharmacies nationwide. This Prescription Drug Reimbursement Request form is for use in exceptional circumstances when you are unable to access your prescription drug benefit, (e.g. Emergencies). Benefits are as shown on your Prescription Drug Summary of Benefits and all covered services are subject to the specific conditions, duration limitations and all applicable maximums of the Group Contract on a usual, customary and reasonable (UCR) cost basis. **The submission of this form does not guarantee reimbursement.**

In the area(s) provided below, please explain in detail the reason(s) you did not use your prescription benefit **and** attach any itemized receipt(s). Submit this completed form to: **Western Health Advantage Mail Service, P.O. Box 5648, Portland OR, 97228-5648.** Please remember to contact your Member Services team at one of the numbers listed below if you need future assistance with locating a participating pharmacy.

PATIENT & INSURED (SUBSCRIBER) INFORMATION			
PATIENT NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	PATIENT'S DATE OF BIRTH	PATIENT'S SEX ☐M ☐F	MEMBER ID NO.
PATIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)			
INSURED'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)		INSURED'S GROUP NO. (OR GROUP NAME)	
INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			

1)

[ ]

Attach itemized receipt(s) suitable for insurance billing purposes here

[ ]

Reason for not utilizing prescription copayment benefit:

2)

[ ]

Attach itemized receipt(s) suitable for insurance billing purposes here

[ ]

Reason for not utilizing prescription copayment benefit:

PLEASE ATTACH A SEPARATE SHEET IF YOU HAVE MORE ITEMIZED RECEIPTS TO SUBMIT

I hereby certify that all information given is correct. I further certify that all drugs and medicines were prescribed by a physician and were purchased for the family member named.

PATIENT'S SIGNATURE (OR PARENT / LEGAL GUARDIAN) _____ DATE _____

Member Services is available to provide assistance or answer questions at 888.563.2250 or 916.563.2250. We can be reached 8 a.m. to 8 p.m., seven days a week (October-March) and 8 a.m. to 8 p.m., Monday-Friday (April-September) or visit medicare.westernhealth.com. If you are hearing impaired, please call our TTY line 711.