

## Prescription Reimbursement Form

Refer to the second page of this form for additional instructions.

### A. Member Information

Member ID \_\_\_\_\_ (This number can be found on your member ID card.)

Member's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

We send any reimbursements and/or communications to the address we have on file unless it has been marked as confidential. If you use a different address than the one we have on file, please provide it below.

Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### B. Claim Information

Was the prescription purchased outside of the U.S.?  Yes  No

If yes, do you reside outside of the U.S.?  Yes  No

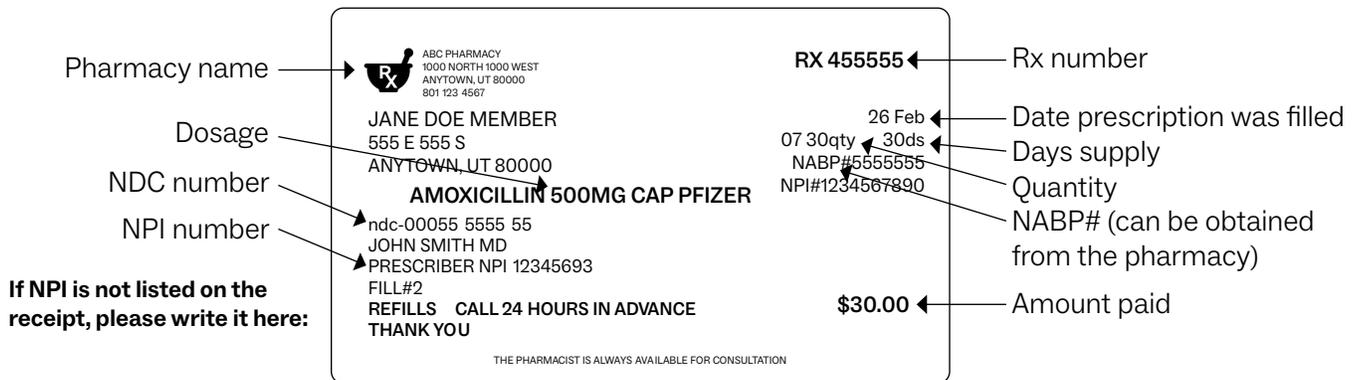
If purchased outside of the U.S., please indicate: Country \_\_\_\_\_ Currency \_\_\_\_\_

Was the prescription purchased as the result of an emergency?  Yes  No

### C. Prescription Documentation (please see Section D. if this claim is for coordination of benefits?)

**If Scripius is your only insurance, please enclose a copy of your receipt. Cash register receipts are not acceptable.**

The following information is required for each prescription receipt submitted:



The diagram shows a sample prescription receipt with the following fields labeled:

- Pharmacy name:** ABC PHARMACY, 1000 NORTH 1000 WEST, ANYTOWN, UT 80000, 801 123 4567
- Dosage:** AMOXICILLIN 500MG CAP PFIZER
- NDC number:** ndc-00055 5555 55
- NPI number:** JOHN SMITH MD, PRESCRIBER NPI 12345693
- Rx number:** RX 455555
- Date prescription was filled:** 26 Feb
- Days supply:** 30ds
- Quantity:** 07 30qty
- NABP# (can be obtained from the pharmacy):** NABP#55555555
- Amount paid:** \$30.00

**If NPI is not listed on the receipt, please write it here:**

The undersigned certifies that the medication(s) identified with this form was/were received by the undersigned for the party named above who is eligible for drug benefits, and that such medication(s) is/are not for an on-the-job injury or covered under another benefit plan or by a prescription assistance program (in full or in part). Participant understands that reimbursement may be subject to Scripius allowed amounts, minus any applicable deductibles or copay/coinsurance. Reimbursement will be paid directly to the participant, and assignment of these benefits to a pharmacy or otherwise is void.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Member or Legal Representative) Month Day Year

## D. Coordination of Benefits (COB) Prescription Documentation

For COB, ask the pharmacy to send secondary claims directly to Scripius. This allows for easy digital processing. If you forgot to have your pharmacy submit your secondary claim, or they were unable to submit the claim for you, use this form to submit any unpaid amounts to Scripius for possible coverage. Please include a detailed Explanation of Benefits (EOB) from your primary insurance company or a detailed prescription/receipt history from the pharmacy.

Documentation must include the information listed in the above section.

- Pharmacy Name
- Pharmacy NABP or NPI number
- Prescription number
- Date of service
- National Drug Code (NDC)
- Quantity dispensed
- Days' supply
- Primary insurance name
- Primary insurance Billing Identification Number (BIN)
- Total amount your primary insurance paid
- Total amount you paid to the pharmacy out of your pocket

**Please enclose a copy of the documentation with this form. Without this documentation, Scripius cannot process your secondary insurance claim and reimburse you.**

## Prescription Reimbursement Form Instructions

Complete all of the information on the front of this form to ensure that your benefits are administered correctly and without delay. Claims must be submitted within 12 months from the date of service or the date processed by the primary insurer.

If you are submitting multiple receipts, fill out one reimbursement form for each receipt. If you are submitting a printout/report from the pharmacy, only one form per person is required. This information can be obtained from your member ID card and the pharmacy where you purchased your prescription(s).

All claims should be submitted by:

### MAIL

#### Scripius

Attn: Pharmacy Services

P.O. Box 30196

Salt Lake City, Utah 84130 0196

### EMAIL

SHAWDPharmacy@selecthealth.org

### FAX

801 650 3279

Claims submitted without the proper identification numbers may be delayed or returned for additional information.

If you have questions, call Pharmacy Services at **888-999-3265** (toll-free) during the following dates and times:

**October 1 to March 31:** Weekdays: 8:00 a.m. to 9:00 p.m. CT / Saturday and Sunday: 9:00 a.m. to 9:00 p.m. CT

**April 1 to September 30:** Weekdays: 8:00 a.m. to 9:00 p.m. CT / Saturday: 10:00 a.m. to 3:00 p.m. CT / Closed Sunday.

Outside of these hours of operation, please leave a message. Your call will be returned within one business day. TTY users, please call **711**.

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This information is available for free in other languages and alternate formats by contacting Scripius: **888-999-3265 (TTY: 711)**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電