

Prescription Reimbursement Form

Refer to the back of this form for additional instructions.

 DMR COB
A. SUBSCRIBER AND MEMBER INFORMATION

 Subscriber ID# 8 0 0 _____ This number can be found on your member ID Card.

 If this is a claim for coordination of benefits and both subscribers are SelectHealth members, list the other subscriber ID# 8 0 0 _____

Patient's Name _____ Patient's Date of Birth _____ (MM/DD/YY)

 Relationship to Subscriber Self Spouse Dependent

 Check here if there is a different address on file

We will send any reimbursement and/or communications to the address in our system for the member (this is usually the same address as the subscriber) unless a confidential address (i.e., address of a custodial parent) is on file for the member.

B. OTHER INSURANCE INFORMATION

 Does the member have other insurance besides SelectHealth? Yes No If yes, please complete the following:

 Insurance Company _____ Is this the member's primary insurer? Yes No

C. CLAIM INFORMATION

Was the prescription purchased outside of the U.S.?

 Yes No If yes, please indicate Country _____ Currency _____

The undersigned certifies that the medication(s) identified below was received by the undersigned for the party(ies) named above who is/are eligible for drug benefits and that such medications(s) is/are not for an on-the-job injury or covered under another benefit plan. The undersigned further authorizes use of such person's social security number for identification purposes. Reimbursement will be paid directly to the participant, and assignment of these benefits to a pharmacy or otherwise is void.

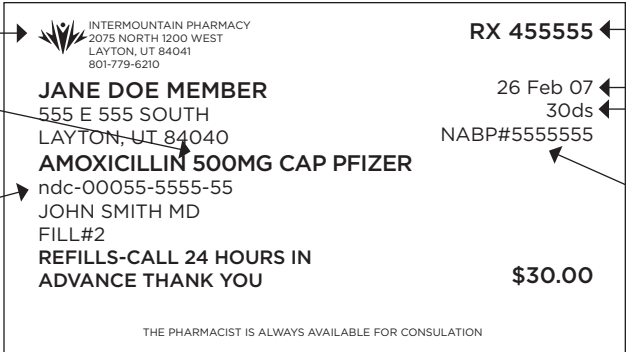
Signature _____ Daytime Ph# (____) _____

(Member, Guardian, or Legal Representative)

D. PHARMACY RECEIPT
Tape one pharmacy receipt in this space. Cash register receipts are not acceptable. Please do not use staples.

If you are submitting multiple receipts, one reimbursement form is required for each receipt. However, if you are submitting a printout/report from the pharmacy, only one form per person is necessary.

The following information is required for each prescription receipt submitted:

Pharmacy name →	 <p style="font-size: small; margin: 0;"> INTERMOUNTAIN PHARMACY 2075 NORTH 1200 WEST LAYTON, UT 84041 801-779-6210 </p> <p style="margin: 0;"> JANE DOE MEMBER 555 E 555 SOUTH LAYTON, UT 84040 AMOXICILLIN 500MG CAP PFIZER ndc-00055-5555-55 JOHN SMITH MD FILL#2 REFILLS-CALL 24 HOURS IN ADVANCE THANK YOU </p> <p style="text-align: right; margin: 0;"> RX 455555 26 Feb 07 30ds NABP#5555555 \$30.00 </p> <p style="font-size: x-small; text-align: center; margin: 0;"> THE PHARMACIST IS ALWAYS AVAILABLE FOR CONSULTATION </p>	← Rx number ← Date prescription was filled ← Days supply (if available) ← NABP# (can be obtained from the pharmacy)
Dosage →		
NDC number →		

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.

The information needed can be obtained from your member ID Card and the pharmacy where you purchased your prescription.

One Prescription Reimbursement Form is required for each claim. Please make copies of each form for your files.

All claims should be submitted to the address below:

SelectHealth

Attn: Pharmacy Services

P.O. Box 30192

Salt Lake City, Utah 84130-0192

Please wait until you receive your ID Card before sending claims to SelectHealth. If you do not have a current ID Card, please call Member Services at **801-442-5038** (Salt Lake area) or **800-538-5038**. Claims submitted without the proper identification numbers may be delayed or returned for additional information.

If you have questions, contact Member Services at the number listed above weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

COORDINATION OF BENEFITS (COB)

If you have additional insurance, you still need to attach the receipt from the pharmacy. You will also need to obtain an Explanation of Benefits (EOB) from your primary insurer. (An EOB is not required if SelectHealth is both your primary and secondary insurance carrier.)