Over-the-Counter/Healthy Foods (OTC) Card **Credit Reimbursement Form**



This form should be used to request credit reimbursement for **eligible** Over-the-Counter/Healthy Foods (OTC) items you have tried to purchase using your plan approved OTC card but were unable to at a retailer. Any credit reimbursement will be applied to your account balance on your OTC card.

Member Information	
Member name (first, middle initial, last name):	Mailing address (street or PO Box, city, state ZIP):
Date of Birth:	Home phone number:
Member ID number:	Group Name or Number (if applicable):
Product Information	
Date Purchased:	Total Amount of Credit Reimbursement Requested:
Name of Retailer (such as CVS, Walgreens, etc.):	
and the amount paid. Reimbursement requests without Please attach a readable original itemized receipt and ci	rcle/highlight the items on the receipt for which you are requesting
credit reimbursement. Make copy of all original receipts	· ·
Please mail the original itemized receipt as proof of payment along with this completed form to:	
Providence Medicare Advantage Plans Attn: OTC/Healthy Foods Credit Reimbursement	
P.O. Box 4447	
Portland, OR 97208-4447	
1 11 0 11	oved amount will be added to your OTC balance which you can I Services at 1-888-682-2400. Only items that are eligible under ursement to your OTC balance.
I hereby certify that all information given is correct.	
Member signature:	Date:
Providence Medicare Advantage Plans Customer Service 503-574-8000 or 1-800-603-2340: TTY: 711	

Service is available 8 a.m. to 8 p.m. (Pacific time), seven days a week