Prescription Drug Reimbursement Request Form

Providence Health Plan

Providence Health Plan 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: **Providence Health Plans, P.O. Box 3125, Portland OR, 97208-3125 or fax 800-249-7714.** Please remember to contact your Customer Service 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) Please provide an itemized receipt which will contain (your pharmacy can provide this information if needed):

- Pharmacy name, address, and phone number
- A prescription number
- Date of service
- National drug code (NDC)
- Quantity dispensed
- Provider name
- Member cost

Reason for not utilizing prescription copayment benefit:

_____
_____
_____
_____
_____
_____

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

[ ] [ ]

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

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

[ ] [ ]

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

Customer Service:

- Portland Metro Area: **503-574-7400**
- All Other Areas: **1-877-216-3644**
- TTY (For the Hearing Impaired): **711**

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

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 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡くださいゐ!

ةظوحلم اذإ:ت نك ثدحتت ركذا اللغة،نإف ت امدخ ةدعاسملا ةيوغللا رفاوتت كل ناجملاب ا ّصلتاب مقرب 1-800-878-4445

(مقرف تاه مصلا مكبلاو: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

របយ័តន៖ េបើសិនជាអនកនិយាយ ភាសាែខមរ, េសវាជំនួយែផនកភាសា
េដាយមិនគិតឈនួ ល
គឺអាចមានសំរាប់ នឹក។ ចូរ ទូរស័ព 1-800-878-4445 (TTY: 711) ។
បំេរអើ

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

ب یرید دهگ. شام بی رگ اریانا صبروبز ینا س تید تلا ک ید، من می گذ فگ فی سرا بزنا ب گر :و ت
ف میشا ب. ب 1-800-878-4445 (TTY: 711) تسا

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคณพดภาษาไทยคณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)