CHA Health Plan

MEMBER REIMBURSEMENT DRUG CLAIM FORM

Complete this form, attach prescription receipts and mail to:
CHA Health Plan
9250 W. Flagler Street, Suite 600
Miami, FL 33174-3460

Cardholder Information	
Cardholder's ID Number:	Group Number:
Cardholder's Name: (Last, First, Middle)	Cardholder's Birthday: (MM/DD/YYYY)
Cardholder's Address: (Street, City, State, ZIP code)	
Gender: ☐ Male ☐ Female	Cardholder's Phone Number:

Reason for Request
Prescription(s) were for:
☐ Coordination of benefits with primary pharmacy or medical plan. ☐ Compound claim
☐ Out of area/urgent/emergency request ☐ Eligibility issue at the pharmacy
☐ Other, please describe:

Pharmacy Information	
Pharmacy Name:	Pharmacy NABP Number:
Pharmacy Address: (Street, City, State, ZIP code)	
Pharmacy Telephone Number:	Pharmacy Signature: Date:

Prescription Information

Please include the **prescription labels** *with this form (**receipts are acceptable**) or a pharmacy printout signed by the pharmacist. You can ask your* **pharmacist** *for assistance in completing the information below.*
Completing this entire form will result in timely processing of your claim.
For questions concerning this claim, please call the toll-free number listed on your pharmacy ID card.

Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits) | | | | | | | | | | |

Medication Name, Strength, Dosage Form:	Physician Name:	NPI/DEA #	Rx Price Paid:

Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits) | | | | | | | | | | |
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #: Rx Price Paid:
Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits) | | | | | | | | | | |
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #: Rx Price Paid:
I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.					
Signature:				Date:	

*Members have up to 36 months from the date of service to request a reimbursement.
*This form is not required, however, all of the information mentioned above will be needed to process request.