KAISER PERMANENTE® thrive

Drug Reimbursement Claim Form

Section I

Members with a prescription benefit may use this form to request reimbursement for (check category):

In Area:

[ ] Kaiser Permanente ID card not received when prescription filled.
[ ] Kaiser Permanente pharmacy was out of stock. (Attach form from pharmacy.)
[ ] Travel immunizations, if a covered benefit.
[ ] Prescription related to an Emergency or Urgent Care visit and Kaiser Permanente Pharmacy was closed.
[ ] Other, please explain: _____

Out of Area: If you are living out of area, either use Kaiser Permanente's mail order service or a network pharmacy. [ ] Prescription for an out of area emergency with a visit to a physician.
[ ] Prescription for an out of area emergency without a visit to a physician.
[ ] Other, please explain_____

Section II

A. Patient Information

Name: _____MR# _____Phone No._____

Birthdate_____ Gender_____

Is the patient covered under Medicare? ☐ No ☐ Yes If yes, ☐ Part A ☐ Part B ☐ Part D

Effective date: _____

B. Prescription Drug Claim Information

RX No.	Date filled	Metric Qty.	Days Supply	Name of Drug	Name of Physician	Cost
					Total	

PLEASE NOTE: The appropriate copayment will be deducted from the reimbursement for each prescription. If applicable, your cap or deductible will be adjusted.

C. Checks Payable to (Please Print)

Subscriber's Name_____ ID No._____

Address_____City_____State_____Zip_____

Certification Statement. IMPORTANT. I certify that the patient information entered on this form is correct, that the patient named eligible for the benefits and that I have received the medication described. I also certify the medication received is not treatment for on-the-job injury.

X_____ Date_____
Patient/Authorized Representative Signature

_____
Print Name (Relationship)

Section III

PLEASE ATTACH THE FOLLOWING TO THIS FORM:

1. Proof of Purchase (original receipt or a copy of both sides of your cancelled check) and
2. Any original prescription bag or other receipt from the pharmacy which indicates the drug name, quantity, prescription number and physician's name. **(Go to the front of this form).**

Dear Kaiser Permanente Member:

If you have coverage under our drug benefit rider, your prescription claim must meet certain criteria before a reimbursement can be made. We have designed this checklist to ensure that your claim will not be delayed in processing due to insufficient information.

_____Have you enclosed the <u>original</u> prescription bag or receipt that states the following information?

1. Name of member
2. Name, address, telephone number of pharmacy
3. Name of prescribing physician
4. Drug name and quantity
5. Prescription number
6. Cost of medicine(s)

(If original documents are unavailable, most pharmacies can issue a receipt for insurance purposes that states the above information.)

_____Do you have proof of payment enclosed? (An original cash register receipt, copy of your canceled check, credit card receipt, or pharmacy issued receipt?
_____Have you completed the Drug Reimbursement Claim Form on the other side
_____Does the claim form and certification statement have your signature and ID#?

Reasons why your claim can be denied:

1. Insufficient data sent in
2. Original receipts are not sent in without providing a detailed explanation
3. Your drug benefit rider obligates you to use a Kaiser Permanente pharmacy or Kaiser network pharmacy for non-emergencies in this area and out of area
4. Not a covered benefit (such as the over-the-counter medicines and medical devices.)
5. Non-Kaiser physician who prescribed medication(s) not associated with an approved in area or out-of-area visit

Please allow 30 days for processing.

Section IV

BEFORE MAILING: Please answer questions on reverse side and enclose supporting documents. MAIL THIS CLAIM AND ATTACHMENTS TO:

Kaiser Permanente Mid-Atlantic Claims
PO Box 371860
Denver, CO 80237-9998

Section V

Any questions or problems relating to the completion of this form, please call 301-468-6000 or if out of area, call 1-800-777-7902.

Go to the front of this form