Member Request for Reimbursement

Phone 1-866-984-6462 / Fax 1-877-355-8070

Directions:

- Please use this form when you have paid full price for a covered prescription drug and want to be reimbursed.
- This form must be completely filled out in order to process your claim(s)
- You must include a copy of all prescription receipt(s) **and** prescription label(s) with your request form in order to receive reimbursement
- All receipts must contain the following information or they will not be accepted:

    1. Prescription number
    2. Date filled
    3. Pharmacy NPI#
    4. Drug name with NDC number
    5. Drug strength, quantity, days supply and amount paid

- If you have any questions or concerns, please call 1-866-984-6462. You can also call if you need help filling out this form.
- The form should be signed by the member (or legal representative) and mailed to:

    Health Plan of Michigan
    Attn: Pharmacy Reimbursement Requests
    777 Woodward Avenue, Suite 600
    Detroit, MI 48226

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Patient Information	
Patient Name:	Address:
Member ID#:	City:
Sex (circle): Male Female	State/Zip:
Date of Birth:	Phone: ( ) -
Contact Person:	Relationship to Patient:

Reason for Request

- □ No Identification Card Available
- □ Copayment Issue
- □ Out of Network Pharmacy Used
- □ Pharmacy Unable to Process Claim Electronically
- □ Emergency
- □ Other

Explain reason for request: _____

_____

_____

Medication Information

Medication #1:

Name of Medication:	NDC:	Date of Fill:	Prescription Number:
_____	_____	_____	_____
Dr. Name:	**NPI:**	**Amount Paid:**	**Quantity/Days Supply:**
_____	_____	_____	_____

Medication #2:

Name of Medication:	NDC:	Date of Fill:	Prescription Number:
_____	_____	_____	_____
Dr. Name:	**NPI:**	**Amount Paid:**	**Quantity/Days Supply:**
_____	_____	_____	_____

I certify that the prescription(s) referred to above have been received and the information is accurate. I certify that the patient for whom this reimbursement is submitted is a covered person and that the prescription(s) given are for the sole use of the member identified. I release all information pertaining to the above claim(s) to the plan administrator, underwriter, sponsored policy holder and/or any person or entity acting on the behalf of the member at their request.

Member Signature*: _____ Date: _____

**If the member is unable to sign, a person who is authorized to do so under the state of law in the state where the individual resides must sign above. This signature certifies that the person is authorized under state law to complete the*

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form on the member's behalf and that all documentation of the authority will be available on request by the plan by the Center for Medicare & Medicaid Services or the state Medicaid agency.