PO Box 66189
Virginia Beach, VA 23466

Direct Member Prescription Reimbursement Form

To receive reimbursement for a prescription, please follow these steps:

- Complete the form below. Be sure to include the member ID number, which can be found on your member ID card.
- You must include the prescription label (the piece of paper that is stapled to the bag that gives specifics about the prescription). Only two prescriptions may be submitted per form.
- Mail this form, the prescription label(s), and receipt(s) to: Pharmacy Authorization Department, Sentara Health Plans, PO Box 66189, Virginia Beach, VA 23466

All requests for pharmacy reimbursement are subject to plan guidelines, policies, and procedures. For example, if a drug requires pre-authorization and was rejected at the pharmacy, it is not eligible for reimbursement. Controlled drugs will not be reimbursed if prior authorization or step edit requests are not given before the pharmacy gets the prescription.

If you have any questions, please call Pharmacy Services at <1-877-552-7401 (TTY: 711), Monday through Friday, 8 a.m. to 6 p.m.> The Pharmacy Benefit Manager (PBM) Pharmacy Call Center is delegated to handle calls outside of internal center hours of operation in accordance with CMS call center requirements.

<table>
<tr><th colspan="4">Member and Prescription Plan Information</th></tr>
<tr><td colspan="3">Member Name (Last, First, Middle Initial)</td><td>Member ID Number</td></tr>
<tr><td colspan="3">Rx Group/Rx GRP Number</td><td>Date of Birth</td></tr>
<tr><td colspan="4">If this is a new address, please check here: ☐</td></tr>
<tr><td rowspan="2">Address</td><td colspan="2">Street</td><td>Apt./Unit No.</td></tr>
<tr><td>City, State</td><td>Zip Code</td><td>Phone Number</td></tr>
</table>

Coordination of Benefits (COB) (Check all that apply.)

☐ This claim was submitted to or partially paid for by another insurance plan.
(Be sure to include the Explanation of Benefits from the other insurance company.)

☐ This prescription was purchased using a discount card. *(Ex: GoodRx, InsideRx, etc.)*

☐ Another Insurance Plan paid for this Claim in error, and that Plan sent you a Collection Letter.
(Be sure to include the collection letter with your claim.)

Explanation for the request.

Prescription Information

This section must be completed by you or your pharmacist.
Attach up to two prescription labels per form.
Attach a copy of your pharmacy receipt(s) with this form.

☐ My physician provided the vaccine or drug.

Pharmacy Name	Pharmacy NPI	Pharmacy Address
Rx Number	Date Filled	Quantity
Rx Name and Strength	Number of Days Supply	NDC#
Doctor's Name	Doctor's NPI	Doctor's Address
Doctor's Phone Number	Price/Amount Paid	Comments
Pharmacy Name	Pharmacy NPI	Pharmacy Address
Rx Number	Date Filled	Quantity
Rx Name and Strength	Number of Days Supply	NDC#

Doctor's Name	Doctor's NPI	Doctor's Address
Doctor's Phone Number	Price/Amount Paid	Comments

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be made according to the limits of your prescription benefit plan and will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

Claims that are hard to read or incomplete may be returned or payment denied. If someone is submitting the claim on the member's behalf, an Authorization of Representation form (Form CMS-1696) or a legal document demonstrating representation must be attached. See the instructions for more information.

Warning: Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including denial of benefits, fines or imprisonment.

PLEASE SIGN AND DATE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The member listed above has received the medication, and I authorize the release of all information contained in this claim to Sentara Health Plans.

_____

Printed Name of Member or Appointed Representative

_____

Signature of Member or Appointed Representative

_____

Date