Sentara® Health Plans

PO Box 66189
Virginia Beach, VA 23466

Direct Member Reimbursement Form

Members can follow the steps below to receive reimbursement for a prescription.

- Complete the Direct Member Reimbursement Form below. Make sure you include the member ID number with this request. The number is located on the 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 per form.
- Mail this form, 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 Member Services at 1-800-881-2166 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

Member and Prescription Plan Information			
Member Name (Last, First, Middle Initial)			Member ID Number
RxGroup/RxGRP Number			Date of Birth
If this is a new address, please check here: ☐			
Address	Street		Apt./Unit No.
	City, State	Zip Code	Phone Number
Coordination of Benefits (COB) Is the drug covered under any other group insurance? ☐ Yes ☐ No If other coverage is Primary, include the Explanation of Benefits (EOB) with this form.			
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.		
Pharmacy Name	Pharmacy Address	
RX Number	Date Filled	Quantity
RX Name and Strength	Number of Days Supply	NDC#
Doctor's Name	Price/Amount Paid	Comments
Pharmacy Name	Pharmacy Address	
RX Number	Date Filled	Quantity
RX Name and Strength	Number of Days Supply	NDC#
Doctor's Name	Price/Amount Paid	Comments

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.

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Printed Name of Member or Parent/Legal Guardian

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Signature of Member or Parent/Legal Guardian

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Date