



## PRESCRIPTION REIMBURSEMENT CLAIM\*

*Use this claim form to seek reimbursement for prescriptions obtained at a non-participating pharmacy.*

**MEMBER INFORMATION: Please submit one form for each individual patient.**

Member Name: \_\_\_\_\_ Soc. Sec. Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Member ID#: \_\_\_\_\_ (9 digit ID# - copy exactly from Samaritan Select ID card) Daytime Phone: \_\_\_\_\_

Member Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Patient Name: \_\_\_\_\_ (if other than member) Relationship:  Spouse  Dependent

Birth Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  Male  Female

Request Reason (e.g., traveling, etc.): \_\_\_\_\_

**PHARMACY INFORMATION: Incomplete information may delay processing or may cause form to be returned.** If you need assistance in filling out necessary information, please refer to your receipt or contact the pharmacy in which the medication was dispensed.

Pharmacy NABP (7 digits)	Rx#	Fill Date	Total Paid	Quantity	Days Supply	Drug NDC# (11 digits)	Prescriber Name	DAW Code

I certify the prescription(s) referred to above have been received and information stated is accurate. I also authorize the release of all information contained herein to Samaritan Select and its agents. I understand that all prescription receipts must be submitted within 180 days of prescription receipt date in order to be processed and considered for reimbursement.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MAIL FORM TO: Samaritan Select  
Samaritan Health Plans  
Attn: Pharmacy Department  
P.O. Box 1310  
Corvallis, OR 97339**

*\*Be sure to attach the original prescription receipt and the cash register receipt to this form. Reimbursement is based on your Plan's maximum benefit. If you have questions, please contact us at (541) 768-5207 or 1-888-435-2396.*