Capital Health PLAN
An Independent Licensee of the Blue Cross and Blue Shield Association

Non- Medicare Prescription Drug Reimbursement Request Form

Member Name: ______________________________

Last *First* *Middle Initial*

Telephone Number: ______________________ Date of Birth: ______________________

Member's ID # (Located on front of card): ______________________

Note: If approved, your reimbursement will be sent to the address on file for the subscriber. If you need to update your address, please contact Member Services at 850-383-3311.

Prescription Drug Reimbursement Checklist:

☐ **Request for Reimbursement:**

Please indicate reason for reimbursement request (ex. COBRA, lost card, out of the area, out of the country, etc):

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☐ **Documentation For Reimbursement:**

Please attach the detailed print-out from your pharmacist for *each* prescription. This print-out must include the following information: member's name, date of birth, name of medication(s), dosage, quantity, purchase amount, pharmacy information, prescriber information, date of purchase, and label from the prescription drug purchase. (*Credit card receipts, bank statements, or cashier's receipts do not provide sufficient information.*)

______________________________ ______________________

Member's Signature Date

Reimbursement requests can take up to 30 days to process. It may take longer if additional information is needed to process the request.

Mail completed form to:

Prime Therapeutics
Commercial Claims Department
PO Box 21870
Lehigh Valley, PA 18002-1870

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