# Member Reimbursement Request Form - Prescription Drugs

## INSTRUCTIONS FOR REIMBURSEMENT REQUEST

1. You must submit your reimbursement request within 180 days of the date of you purchased the prescription drug. Reimbursement for approved charges will be mailed within 30 days of receipt of complete documentation. Copayments will apply.
2. Complete a separate form for each member who is requesting reimbursement. Only one form is needed per member.
3. The member who received the prescription drug must sign this form. If the member is under 18 years old, the form must be signed by the parent or guardian who is enrolled in Sharp Health Plan.
4. Send this completed form and the following documents to Sharp Health Plan. Keep copies of all items sent to Sharp Health Plan.
   - Label receipt from the prescription drug, which includes pharmacy name, prescribing physician, drug name and dosage
   - Cash register receipt as proof of payment
5. Fax or mail the form and required documents to:

Sharp Health Plan
Attn: Customer Care
8520 Tech Way, Ste. 200
San Diego, CA 92123-1450
Tel 1 (800) 359-2002
Fax (619) 740-8571

## MEMBER INFORMATION - Complete this section for all reimbursement requests.

| LAST NAME | | FIRST NAME | |
|---|---|---|---|
| STREET ADDRESS | | | CITY |
| STATE | ZIP CODE | PHONE NUMBER | |
| DATE OF BIRTH | | SHARP HEALTH PLAN ID # | |

PLEASE EXPLAIN WHY YOU PAID FOR THIS MEDICATION, INSTEAD OF USING YOUR SHARP HEALTH PLAN COVERAGE.

## PARENT/GUARDIAN ENROLLED IN SHARP HEALTH PLAN - Complete this section if the member is under 18 years old.

| LAST NAME | | FIRST NAME | |
|---|---|---|---|
| STREET ADDRESS | | | CITY |
| STATE | ZIP CODE | PHONE NUMBER | |
| DATE OF BIRTH | | SHARP HEALTH PLAN MEMBER ID # | |

## CERTIFICATION STATEMENT - Read, sign and date.

I certify that the above information is true and the attached material is correct and unaltered and that the expenses were incurred by the patient named above. I understand all documents submitted become the property of Sharp Health Plan and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from Sharp Health Plan and/or subject to civil or criminal penalties. I authorize the release of any information needed to review or process this request.

MEMBER'S SIGNATURE (PARENT/GUARDIAN IF CHILD) _____ DATE _____

| SHARP HEALTH PLAN USE ONLY | CSR NO. |
|---|---|

(07/10)