



Ohana Direct Member Reimbursement Form



Rev. 05/10

Complete and return this form when you have purchased a covered prescription drug at retail cost and are seeking reimbursement. Submit this form with the original prescription label receipt(s). Cash register and credit card receipts alone are not acceptable as proof of purchase. Claims forms without the required information cannot be processed. Reimbursement is not guaranteed.

Member Information

Name: _____ Date of Birth: _____ ID Number: _____

Street Address: _____ Apt/Unit #: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____ Client ID: 8257

Reason for Request

| | |
|---|--|
| <input type="checkbox"/> No Identification Card Available | <input type="checkbox"/> Copayment Inquiry |
| <input type="checkbox"/> Out of Network Pharmacy Used | <input type="checkbox"/> Pharmacy Unable to Process Claim Electronically |
| <input type="checkbox"/> Emergency - Please Describe | <input type="checkbox"/> Other - Please describe |

Pharmacy/Prescription Information

Please attach detailed prescription label receipts or ask your pharmacist to complete the remaining information. See page two of this form for additional space.

We cannot process your claim without this information.

| | | | | |
|-----------|--------------|-------------|--------------|-------------|
| Drug Name | Date of Fill | Quantity | Day Supply | Amount Paid |
| NDC | Dr. Name | Dr. DEA/NPI | Pharmacy NPI | RX Number |

Special Instructions:
 Prescription Label receipt must have the requested information clearly legible or reimbursement may be delayed or denied.
 Please mail prescription label receipt(s), cash register receipts and this completed form to:
Ohana Health Plan
Reimbursement Department
PO Box 31577
Tampa, FL 33631-3577

I certify that the prescription(s) referred to above have been received and information stated is accurate. I certify that the patient for whom this claim is made is a covered person and that the prescription is for the sole use of the named patient. I release all information pertaining to the above claim(s) to the plan administrator, underwriter, sponsored policy holder and/or any person or entity acting on behalf of the patient at their request.

Enrollee Signature*: _____ Date: _____

*If the individual cannot sign, a person who is authorized to do so under state law in the state where the individual resides must sign above. This signature certifies that the person signing is authorized under state law to complete this form and that all documentation of this authority is available upon request by the plan from the individual state Medicaid agency or by the Centers for Medicare & Medicaid Services, the federal agency that runs Medicare.

