US FAMILY HEALTH PLAN

COB PRESCRIPTION CO-PAY REIMBURSEMENT FORM

(please complete one form per family member)

TUFTS Health Plan

INSTRUCTIONS

1. To request reimbursement, please submit the following to the address listed at the bottom of this form (any missing information may result in delay or denial of the request):
   a. This completed and signed reimbursement form b. Proof of payment for the services being requested for reimbursement
2. Please check your benefit document for the filing deadline associated with member reimbursement requests. Most completed reimbursement requests are processed within 30 days. Incomplete requests may take longer.
3. Reimbursement will be sent to the Plan subscriber (see Help Sheet for definition) at the address USFHP has on record (To view your address of record, please log on to the secure member portal through usfamilyhealth.org or call Member Services at the number listed on the back of your ID card.)
4. Retain a copy of all receipts and documentation for your records.

SUBSCRIBER INFORMATION

Subscriber Last Name	First Name	Middle Initial

PATIENT INFORMATION

Patient's USFHP Member Identification #	Email Address

Last Name	First Name	Middle Initial

Date of Birth (MM/DD/YYYY)	Telephone Number

CLAIM INFORMATION

(This section must be completed.)

Prescription Name	Amount Paid	Receipt from pharmacy (Enclose with this form)

Prescription Name (for additional prescriptions)	Amount Paid
	$
	$
	$
	$
Total amount paid	$

I attest that the above information is true and accurate and that the prescription was paid for in the amount requested as indicated above.
I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims. I understand that reimbursement payment will be made to the Plan subscriber and will contain information about the prescription (e.g., prescription name, amount paid). I also understand that USFHP may request any additional information it deems necessary to verify that the prescription(s) were received and payment was made.

Member signature is required

Printed name	Signature	Date

CHECKLIST

- ❑ I have completed and signed this form in its entirety.
- ❑ I have enclosed proof of payment (see the help sheet for an example of proof of payment).
- ❑ I understand that most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

Please submit this form and all documentation to:
US FAMILY HEALTH PLAN • MEMBER REIMBURSEMENT CLAIMS, P.O. BOX 495 • CANTON, MA 02021-0495

COB PRESCRIPTION CO-PAY REIMBURSEMENT HELP SHEET

FIELD NAME	DESCRIPTION
Subscriber Information	Subscriber is the person: • who enrolls in US Family Health Plan and signs the membership application form on behalf of him/herself and any dependents. • in whose name the premium is paid.
Patient's USFHP Member Identification #	Member Identification # with suffix, found on the front of the US Family Health Plan Member card.
Patient's Name	Last and First names and Middle Initial of patient who received services.
Patient's Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits).
Prescription Name	Name of the medication as it appears on your pharmacy receipt.
Total Amount Paid	Total amount for which you are requesting reimbursement.
Receipt from Pharmacy	You must include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will only be accepted for diabetic supplies.