COMMUNITY HEALTH CHOICE

Community Health Choice (HMO D-SNP)
Prescription Drug Member Reimbursement Form

You are not required to use this form to request a reimbursement. This form encompasses standard reimbursement requests, as well as requests for Compound Claims. If your drug is not a compound some of the requested fields may not be applicable. Please fill out as much information as you have available. Any blank fields we will attempt to obtain directly from your pharmacy.

If you have questions about this form, please call Member Service at 1-833-276-8306 toll-free or local 1-713-295-5007, (TTY: 711) from October 1 to March 31, 8:00 am to 8:00 pm, 7 days a week and April 1 through September 30, Monday through Friday, 8:00 am to 8:00 pm CST. On certain holidays your call will be handled by our automated phone system.

Please indicate the reason for your reimbursement request.

- ☐ I did not have my member ID card at the time of purchase.
- ☐ I was charged for medication(s) received during an urgent care/emergency visit.
- ☐ I was administered a Medicare Part D covered vaccine in my doctor's office.
- ☐ Primary coverage is with another insurance carrier. (Coordination of Benefits)
- ☐ Other: _____

You must submit your Part D (prescription drug) claim to us within 36 months of the date you received the service, item, or drug.

Member ID The member ID can be found on your Community Health Choice (HMO D-SNP) ID card.			
Member ID			
Member Information			
Last Name	First Name		
Street Address			
City	State	ZIP code	
Date of Birth	Sex ☐ M ☐ F	Date of injury/illness	Was this related to an auto accident? Yes ☐ No ☐
Was this related to an injury? Yes ☐ No ☐	Other health insurance? Yes ☐ No ☐		
Name of other health insurance	Policy number		
Member's Signature	Date	Phone	
Your right to confidentiality: We will not release any information about you unless you request in writing or when release is necessary to process or review a claim (ex: to another insurance company). We will tell you which information we release to whom, upon your request.			