

INSURED REIMBURSEMENT FORM

DIRECTIONS:

1. This form must be completely filled out in order to process your claim. Please be thorough.
2. Attach prescription receipts to the back of this form.
3. The prescription information section is to be filled out using the prescription receipt and/or label. Ask the filling pharmacy for the "NDC Code" and "Pharmacy ID number".
4. State reason for using a non-network pharmacy.
5. Sign form, then mail form and receipts to:

Health Plan of Nevada, Attn: CR&R, PO Box 15645, Las Vegas, NV 89114-15645

Note: You will be reimbursed according to the contracted rate less co-payment and/or coinsurance for your specific plan benefit design unless you receive a brand name drug which has a generic equivalent. See your Prescription Drug Rider for details.

INSURED'S INFORMATION – Please Print		
Patient's Name		
First	Last	
Insured's ID #	Phone Number (Day)	
Mailing Address		
City	State	Zip Code

Note: You must use a contracted network pharmacy except in special circumstances, i.e. emergencies.

Please explain reason for submitting form: _____

PRESCRIPTION INFORMATION

Rx #	*NDC Code	Date Rx Filled	Prescriber's Name	*Pharmacy ID# (NCPDP#)	Drug Name & Strength	Qty. (metric)	Days Supply	Total Amount Paid by Insured

I hereby certify that the above statements, including accompanying statements, are to the best of my knowledge true, correct, and complete. I hereby authorize any physician or service provider to furnish and disclose all known facts concerning this claim, upon request from the claim administrator. I will reimburse the plan for any overpayment made to me or on my behalf due to error on this form.

***Ask the filling pharmacy for this information**

INSURED'S SIGNATURE _____ **DATE** _____