



Member Prescription Drug Reimbursement Form

To seek reimbursement for covered prescription drugs from Security Administrative Services, complete the member and pharmacy information below and **attach the prescription detail which must include the following:**

- Drug name and N.D.C. number
- Prescription number
- Pharmacy name
- Provider who prescribed the medication
- Date of service
- Drug quantity
- Reimbursement amount

MEMBER INFORMATION

Name _____

Address _____

City _____ State _____ ZIP _____

Telephone (____) _____

Member subscriber number _____

Other insurance coverage: Prescription(s) has previously been submitted to another carrier other than Security Administrative Services for primary payment Yes No

PHARMACY INFORMATION

Name _____

Address _____

City _____ State _____ ZIP _____

Telephone (____) _____

Return this completed form and prescription detail to the address below. Please note that completion of this form does not guarantee payment.

The prescription detail must be attached in order for Security Administrative Services to process your request.

Mail to: Pharmacy Benefit Specialist – SAS
Security Health Plan
P.O. Box 8000
Marshfield, WI 54449-8000

Call: 1-877-873-5611 or 715-221-9604
from 8 a.m. to 5 p.m., Monday through Friday
Fax: 715-221-9989
TTY: 1-877-727-2232