

## Medicare Advantage

# Member Prescription Drug Reimbursement Request

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

- Drug name and N.D.C. number
- Date of service
- Prescription number
- Drug quantity
- Pharmacy name
- Day supply
- Provider or prescriber's name
- Reimbursement amount

### Member information

Name \_\_\_\_\_ Subscriber ID number \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_ Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

Reason pharmacy did not process online \_\_\_\_\_

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

### Pharmacy information

Name \_\_\_\_\_ Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

**Note:** All covered Part D prescription claims should be run online at a network pharmacy. Coverage and amount reimbursed will be based on the reason the claim was not processed online at the pharmacy.

**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 Health Plan to process your request.**

Mail to: Pharmacy Benefit Specialist  
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: 711