



## Member Prescription Drug Reimbursement Form

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
- 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 Health Plan 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 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: 1-877-727-2232