Direct member reimbursement form

Please submit complete forms and attachments to:

CareOregon Advantage: Attention Pharmacy DMR
315 SW Fifth Avenue Portland, Oregon 97204

Please check that the information on this form is complete and legible. If the decision for reimbursement is favorable you will receive notice and payment within 14 days from the date that we receive the request. To help us process the request, please include the following: I. Copy of prescription labels AND proof of payment (register receipt); OR II. Pharmacy printout signed by a pharmacist with the completed form. Please retain copies for your record(s).

Please explain the reason(s) for the request(s):

Member information

Last name: _____ First name: _____ DOB: _____

Member ID: _____ Gender: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Person completing the form ◯ same as member above ◯ parent/legal guardian

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Pharmacy information

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Requested drug(s) for reimbursement

Date of service	Quantity	Medication name, strength and form	Day supply	Amount
1.				
2.				
3.				
4.				
5.				
6.				
7.				
		Total:		

Continued >

Signature of person completing the form

By signing this form below, I certify that all information provided on this form is correct to the best of my knowledge; the prescription(s) submitted are for me or members of my family who are eligible and are for the sole use of the named member above. I authorize release of any eligible, contact to the pharmacy and doctor office as necessary to obtain information pertaining to this claims(s) to CareOregon and I understand that fraudulent acts (including false claims) may be subjected to civil or criminal penalties.

Signature: _____ Date: _____