SHARP HEALTH PLAN

Member Reimbursement Request Form
Prescription Drugs

Instructions

1. You must submit your reimbursement request within 180 days of the date you purchased the prescription drug. Reimbursement for approved charges will be mailed within 30 days of receipt of complete documentation. Copayments will apply.
2. Complete a separate form for each member who is requesting reimbursement. Only one form is needed per member.
3. The member who received the prescription drug must sign this form. If the member is under 18 years old, the form must be signed by the parent or guardian who is enrolled in Sharp Health Plan.
4. Send this completed form and the following documents to Sharp Health Plan. Keep copies of all items sent to Sharp Health Plan:
   - Label receipt from the prescription drug, which includes pharmacy name, prescribing physician, drug name and dosage.
   - Cash register receipt as proof of payment.

Submit

Please submit the finished form by mail, in person, or fax:

By Mail or In Person:
Attention: Customer Care
Sharp Health Plan
8520 Tech Way, Suite 200
San Diego, CA 92123

By Fax:
Attention: Customer Care
1-619-740-8571

If you need assistance, we're here to help.
You can call Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002, or email us at customer.service@sharp.com. We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

Member Information

First name:	Last name:	Middle initial:
ID#:	Phone number: 1- - -	Birth date (MM/DD/YY): (/ /)
Home address (NOTE: Approved reimbursements will be mailed to this address - P.O. box is not allowed.):		
City:	State:	ZIP code:
Please explain why you paid for this medication, instead of using your Sharp Health Plan coverage.:		

Prescription Information

For over-the-counter reimbursement requests related to health care reform, include your doctor's prescription.

Prescription 1

Prescriber name:		Diagnosis:	
Date filled (MM/DD/YY): (/ /)	RX number:	Quantity:	Day supply:
Drug name and strength:			Amount paid: $
Pharmacy name	Pharmacy address:		

Prescription 2 (if applicable)

Prescriber name:		Diagnosis:	
Date filled (MM/DD/YY): (/ /)	RX number:	Quantity:	Day supply:
Drug name and strength:			Amount paid: $
Pharmacy name:	Pharmacy address:		

Parent/Guardian enrolled in Sharp Health Plan (complete this section if the member is under 18)

First name:	Last name:	Middle initial:
ID#:	Phone number: 1- - -	Birth date (MM/DD/YY): (/ /)
Home address (P.O. box is not allowed):		
City:	State:	Zip code:

Certification Statement

I certify that the above information is true and the attached material is correct and unaltered and that the expenses were incurred by the patient named above. I understand all documents submitted become the property of Sharp Health Plan and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from Sharp Health Plan and/or subject to civil or criminal penalties. I authorize the release of any information needed to review or process this request.

Member's name (Parent/Guardian if child):	Member's signature (Parent/Guardian if child):	Date (MM/DD/YY): (/ /)

INTERNAL USE ONLY: CSR NO. _____

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.
IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.