Prescription Drug Reimbursement Claim Form

This form is to be used for reimbursement of covered preventative prescription drugs only. Preventive Service Only (PSO) plans do not include prescription drug coverage, with the exception of preventive drugs as mandated by the Affordable Care Act (ACA). Preventative drugs are covered at 100% and will be reimbursed at 100% (quantity limitations may exist).

Please complete this form and include a copy of your original payment receipt and proof of your prescription, which may be a copy of the prescription insert/profile supplied by the pharmacy with your prescription. **SBMA will not process your claim if you do not include these items.**

Date Submitted: _____

Number of Prescriptions Attached: _____

PART ONE: Member Information

Member Name: _____

Member Number: _____ Daytime Telephone Number: _____

Mailing Address: _____

PART TWO: Claimant Information *(Please use a separate form for each family member.)*

Claimant's Name: _____

Claimant's Date of Birth (MM/DD/YY): _____

The patient is: ☐ Male ☐ Female / ☐ Member ☐ Spouse ☐ Child/Covered Dependent

☐ Check if another insurance policy provided partial coverage. If so, please attach the Explanation of Benefits (EOB) from the other policy provider.

The undersigned certifies that the prescription receipts attached herein were received by the undersigned for the member noted above, who is eligible for preventative prescription drug benefits, and that such prescriptions were not for an on-the-job Injury or covered under any other benefit plan. The undersigned authorizes the release of any and all information to the plan administrator, underwriter, sponsor, policyholder, employer, and their agents for use in connection with the benefit plan program. Information may also be used for other reporting and analysis purposes without identification of the undersigned or the member noted above. The undersigned further authorizes the use of such persons' member number for identification purposes and further recognizes that reimbursement will be paid directly to the member and assignment of these benefits to a Pharmacy or other party is void.

_____

Signature of Patient, Guardian, or Legal Representative

Please mail the following documents to:

- ☐ Completed Prescription Drug Reimbursement Claim Form
- ☐ Copy of the original payment receipt
- ☐ Copy of prescription insert/profile (supplied by pharmacy with your prescription)

SBMA
Attention: Member Claims
2307 Fenton Pkwy # 107-126
San Diego, CA 92108

You may also email scanned copies of your documentation to claims@sbmamec.com.

Please be sure to ask your provider if a generic drug is right for your condition. If so, ask your doctor to allow your pharmacy to fill your prescriptions with generic medications. Generic drugs contain the same ingredients as their brand-name counterparts. When you use generic drugs, you get the same quality as brand-name drugs - at a lower cost. If there is no generic available, ask your doctor if a preferred drug is available to treat your condition. **Only Healthcare Reform-approved preventive drugs—as outlined in the Affordable Care Act (ACA) will be reimbursed.**

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