

## Member Reimbursement Drug Claim Form

Coverage provided by Kaiser Foundation Health Plan of Washington  
and Kaiser Foundation Health Plan of Washington Options, Inc.

### Cardholder Information

Cardholder's ID Number:	Group / Employer / Name and Number:	
Cardholder's Name: (Last, First, Middle)	Cardholder's Birth date: (MM/DD/YYYY)	
Cardholder's Address: (Street, City, State, ZIP)	Cardholder's Telephone Number: (   )	

### Patient Information

Prescription(s) were for:

Patient's Name: (First, Middle, Last)	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Patient's Birth date: (MM/DD/YYYY)
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### Custodial Parent Information

For reimbursement requests from a Parent for a child (under the age of 18) when the requesting Parent meets both of the following requirements:

1. Parent is not enrolled in the same Kaiser Permanente Health plan as the child
2. Parent does not reside in the same household as the subscriber under the child's Kaiser Permanente plan

**If your child is covered under two or more health plans, state law determines the order of benefits for processing claims.**

Legal Custodian's Name:	Legal Custodian's Contact Phone Number: (   )
Custodian Requesting Reimbursement Name:	Custodian Requesting Reimbursement Contact Phone Number: (   )

Address payment is to be mailed to:

### Reason for Request

<input type="checkbox"/> Coordination of benefits with primary prescription or medical plan	<input type="checkbox"/> Compound claim <input type="checkbox"/> Urgent/emergency care out of area	<input type="checkbox"/> Eligibility issue at the pharmacy <input type="checkbox"/> Other, please describe:
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## Pharmacy Information

Pharmacy Name:		Pharmacy NABP Number:
Pharmacy Address: (Street, City, State, ZIP)		
Pharmacy Telephone Number: (    )	Pharmacist Signature:	Date:

## Prescription Information

**The following must be included with your form submission for timely processing:** Pharmacy medication receipts containing the drug information such as National Drug Code (NDC), drug name, quantity, copay or amount paid and payor name (register receipts alone are not acceptable as they do not contain the needed drug information). A pharmacy printout containing this information and signed by the pharmacist can also be submitted. You can ask your pharmacist for assistance in completing the information below. Completing this entire form and including requested information will result in timely processing of your claim. For questions concerning this claim, please call the toll free number listed on your pharmacy ID card.

For reimbursement of FDA-approved over-the-counter (OTC) contraceptive products, include Date Filled, Quantity, Days Supply, NDC (located on product packaging), Product Name and Price Paid with proof of payment.

Date filled:	Rx Number:	Rx: (check one) <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)  _ _ _ _ _ _ _ _ _ _ _ _
Medication Name, Strength, Dosage, Form:			Physician Name:		NPI/DEA #
Date filled:	Rx Number:	Rx: (check one) <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)  _ _ _ _ _ _ _ _ _ _ _ _
Medication Name, Strength, Dosage, Form:			Physician Name:		NPI/DEA #
Date filled:	Rx Number:	Rx: (check one) <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)  _ _ _ _ _ _ _ _ _ _ _ _
Medication Name, Strength, Dosage, Form:			Physician Name:		NPI/DEA #

I certify that all information on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Signature:	Date:
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# Notice of Nondiscrimination

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (“Kaiser Permanente”) comply with applicable Federal and Washington state civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
  - Assistive devices (magnifiers, Pocket Talkers, and other aids)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at **1-888-901-4636** (TTY **711**).

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with our Civil Rights Coordinator by writing to P.O. Box 35191, Mail Stop: RCR-A3S-03, Seattle, WA 98124-5191 or calling Member Services at the number listed above. You can file a grievance by mail, phone, or online at **kp.org/wa/feedback**. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697** (TDD)  
Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at **<https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>**, or by phone at **800-562-6900, 360-586-0241** (TDD). Complaint forms are available at **<https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>**

# Multi-language Interpreter Services

**English: ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-901-4636 (TTY 711)**.

**Español (Spanish): ATENCIÓN:** Si habla español, tiene disponibles servicios de ayuda con el idioma sin cargo. Llame al **1-888-901-4636 (TTY 711)**.

**中文 (Chinese) :** 注意：如果您說中文，您可以免費獲得語言援助服務。請致電 **1-888-901-4636 (TTY 711)**。

**Tiếng Việt (Vietnamese): CHÚ Ý:** Nếu quý vị nói tiếng Việt, quý vị có thể sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí của chúng tôi. Xin gọi số **1-888-901-4636 (TTY 711)**.

**한국어 (Korean): 참고:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 제공해 드립니다. **1-888-901-4636(TTY 711)**번으로 문의하십시오.

**Русский (Russian): ВНИМАНИЕ!** Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Звоните по номеру **1-888-901-4636 (TTY 711)**.

**Tagalog: PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-901-4636 (TTY 711)**.

**Українська (Ukrainian): УВАГА!** Якщо ви розмовляєте українською мовою, вам доступні безкоштовні послуги перекладу. Телефонуйте за номером **1-888-901-4636 (TTY 711)**.

**ភាសាខ្មែរ ( Khmer ):** សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺ មានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ **1-888-901-4636 (TTY 711)**។

**日本語 (Japanese): 注意事項 :** 無料の日本語での言語サポートをご利用いただけます。**1-888-901-4636 (TTY 711)** まで、お電話にてご連絡ください。

**አማርኛ (Amharic):** ማሳሰቢያ፡ የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አገዛ አገልግሎቶች፣ በነጻ ለእርስዎ ይቀርባሉ። ወደ **1-888-901-4636 (TTY 711)** ይደውሉ።

**Oromiffa (Oromo): XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa yoo ta'e, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. **1-888-901-4636 (TTY 711)** irraatti bilbilaa.

**ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। **1-888-901-4636 (TTY 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

**العربية (Arabic):** انتباه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجاناً. اتصل بالرقم **1-888-901-4636 (TTY 711)**

**Deutsch (German): ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-901-4636 (TTY 711)**.

**ພາສາລາວ (Lao): ໄປດຊາບ:** ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ແມ່ນຈະມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທ **1-888-901-4636 (TTY 711)**.