'ohana health plan

# 'Ohana Health Plan Direct Member Reimbursement Form

Use this form if you pay for a covered prescription drug at retail cost and want to be repaid. **Fill out the form. Send it to the address below. Also send the original prescription label and receipt(s).** We do not accept cash and credit card receipts alone as proof of purchase. **Claim forms that do not have all information will not be processed. Repayment is not guaranteed.**

## Member Information

**Name:**_____ **Date of Birth:**_____ **ID Number:** _____

**Street Address:**_____ **Apt/Unit #:**_____ **Phone #:** _____

**City:**_____ **State:**_____ **ZIP Code:**_____ **Client ID:** 6257

## Reason for Request

| | | | |
|---|---|---|---|
| ☐ | No Identification Card Available | ☐ | Co-payment Inquiry |
| ☐ | Out-of-Network Pharmacy Used | ☐ | Pharmacy Unable to Process Claim Electronically |
| ☐ | Emergency – Please Describe | ☐ | Other – Please Describe |

## Pharmacy/Prescription Information

Please attach **detailed prescription label receipts.** Or ask your **pharmacist** to fill out the information below. **See page two of this form for more space.**

**We must have this information to process your claim.**

| ***Drug Name*** | ***Date of Fill*** | ***Quantity*** | ***Day Supply*** | ***Amount Paid*** |
|---|---|---|---|---|
| | | | | |
| ***NDC*** | ***Dr. Name*** | ***Dr. DEA/NPI*** | ***Pharmacy NPI*** | ***RX Number*** |
| | | | | |

**Special Instructions:**

We must be able to read the prescription label receipt. If we cannot, repayment may take longer or be denied. Please mail prescription label receipt(s), cash register receipt(s) and this completed form to:

**'Ohana Health Plan**
**Reimbursement Department**
**P.O. Box 31577**
**Tampa, FL 33631-3577**

I confirm the following about the items listed on this form. The prescription(s) have been received. The information is correct. The patient listed is a covered person. The drug is for the use of that patient. The information about the claim(s) may be released. It can be given to these people:

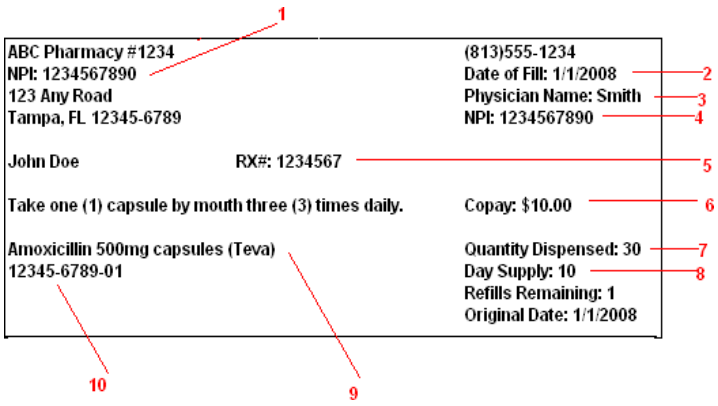
- plan administrator
- underwriter
- sponsored policy holder
- anyone acting for the patient at their request

Member Signature*:_____ Date: _____

*Is the enrollee not able to sign? Then another person must sign. He or she must be approved to sign under the laws of the state where the enrollee lives. This signature means that the person who signs is approved under state law to fill out this form. It also confirms that proof of this is available if it is asked for. This request can be from the plan or from the state Medicaid agency. It can also be from the Centers for Medicare & Medicaid Services (CMS). CMS is the federal agency that runs Medicare.

***Sample Prescription Label***

The label below is a sample. Use it as a guide. It can help you find the information you need. Each pharmacy has its own type of label. Please contact your pharmacy to get help with any missing information. Do you need help completing this form? Please contact us. Call the Customer Service phone number listed on the back of your member ID card.




1. **Pharmacy NPI Number**
2. **Date of Fill**
3. **Physician Name**
4. **Physician NPI Number**
5. **Prescription (RX) Number**
6. **Amount Paid**
7. **Quantity Dispensed**
8. **Day Supply**
9. **Drug Name**
10. **NDC**

| **Pharmacy /Prescription Information (Continued from Page 1)** | | | | |
|---|---|---|---|---|
| | | | | |
| ***NDC*** | ***Dr. Name*** | ***Dr. DEA/NPI*** | ***Pharmacy NPI*** | ***RX Number*** |
| ***Drug Name*** | ***Date of Fill*** | ***Quantity*** | ***Day Supply*** | ***Amount Paid*** |
| ***NDC*** | ***Dr. Name*** | ***Dr. DEA/NPI*** | ***Pharmacy NPI*** | ***RX Number*** |
| ***Drug Name*** | ***Date of Fill*** | ***Quantity*** | ***Day Supply*** | ***Amount Paid*** |
| ***NDC*** | ***Dr. Name*** | ***Dr. DEA/NPI*** | ***Pharmacy NPI*** | ***RX Number*** |

'Ohana Health Plan complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat people differently because of race, color, national origin, age, disability or sex.

'Ohana Health Plan provides 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, other formats)

'Ohana Health Plan provides 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 **1-888-846-4262** (TTY **711**).

If you believe that 'Ohana Health Plan has failed to provide these services or discriminated in another way, you can file a grievance with:

'Ohana Health Plan
Attn: Grievance Department
949 Kamokila Boulevard
Suite 350
Kapolei, HI 96707
Toll-free: **1-888-846-4262**
TDD/TTY: **711**
Fax: **1-813-865-6861**

You can file a grievance in person or by mail or fax. If you need help filing a grievance we are available to help you. Call Customer Service toll-free at **1-888-846-4262** (TTY: **711**).

You can also file a grievance 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, D.C. 20201
**1-800-368-1019**, **800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

(English) Do you need help in another language? We will get you a free interpreter. Call **1-888-846-4262** (TTY: **711**).

(Cantonese) 您需要其他語言的協助嗎？我們提供您免費的口譯服務。請致電 **1-888-846-4262** (TTY：**711**)。

(Chuukese) En mi mochen emon chon awewe/chon chiaku non pwan ew fos? Sipwe angei emon chon chiaku esapw kame. Kekkeri **1-888-846-4262** (TTY: **711**).

(French) Èske ou bezwen èd nan yon lòt lang? N ap mete yon entèprèt adispozisyon w, gratis. Rele **1-888-846-4262** (TTY: **711**).

(German) Benötigen Sie Hilfe in einer anderen Sprache? Wir stellen Ihnen kostenlos einen Dolmetscher zur Verfügung. Sie erreichen uns unter: **1-888-846-4262** (TTY: **711**).

(Hawaiian) **Pono ʻoe i ke kōkua ma ka ʻōlelo ʻē aʻe? E loaʻa iā mākou kahi unuhi ʻōlelo unuhi ʻōlelo. E kelepona iā 1-888-846-4262 (TTY: 711).**

(Ilocano) Masapulmo kadi ti tulong iti sabali a lengguahe? Ipaayandaka iti libre nga interpreter. Umawag iti **1-888-846-4262** (TTY: **711**).

(Japanese) 他の言語でのサポートが必要ですか?通訳を無料でご用意します。**1-888-846-4262** (TTY: **711**) までお電話ください。.

(Korean) 다른 언어로 도움을 받으셔야 합니까? 무료 통역사를 지원해 드립니다. **1-888-846-4262** (TTY: **711**) 번으로 연락해 주십시오.

(Mandarin) 您是否需要其他语言的帮助？我们将为您提供免费的翻译服务。请致电 **1-888-846-4262** (TTY: **711**)。

(Marshallese) Kwōj ke aikuj jibañ kin bar juon kajin? Kim naj lewaj juon riukok ejellok wonnen. Kūrlok **1-888-846-4262** (TTY: **711**).

(Samoan) O e manaomia se fesoasoani i se isi gagana? Matou te sueina se faaliliu upu e le totogiina. Vala'au le **1-888-846-4262** (TTY: **711**).

(Spanish) ¿Necesita ayuda en otro idioma? Le conseguiremos un intérprete gratuito. Llame al **1-888-846-4262** (TTY: **711**).

(Tagalog) Kailangan ba ninyo ng tulong sa ibang wika? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa **1-888-846-4262** (TTY: **711**).

(Tongan) ʻOku ke fiemaʻu tokoni ʻi ha toe lea kehe? Te mau ʻomi taʻetotongi ha tokotaha fakatonulea. Tā ki he **1-888-846-4262** (TTY: **711**).

(Vietnamese) **Quý vị có cần trợ giúp bằng ngôn ngữ khác không? Chúng tôi sẽ cung cấp cho quý vị một phiên dịch viên miễn phí. Hãy gọi đến số 1-888-846-4262 (TTY: 711).**

(Visayan) Nagkinahanglan ka bag tabang gikan sa laing pinulongan? Hatagan ka namo og libreng tighubad. Tawag sa **1-888-846-4262** (TTY: **711**).