Chorus Community Health Plans
PO Box 1997 - MS 6280 | Milwaukee, WI 53201-1997
Toll-free: 1-844-201-4677 | chorushealthplans.org

Pharmacy Direct Reimbursement Claim Form

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services at 1-844-201-4677
Otherwise please return completed form to Chorus Community Health Plans Pharmacy Services by fax at 1-844-201-4675

Member Information

PATIENT NAME (LAST, FIRST, MI) _____ DATE OF BIRTH _____ ☐F ☐M GENDER _____ MEMBER ID NO. _____

STREET _____ CITY _____ STATE _____ ZIP _____ DAYTIME PHONE _____

☐ PLEASE CHECK IF NEW ADDRESS:

PLAN NAME / PLAN TYPE _____ GROUP NUMBER _____

Is Chorus Community Health Plans the patient's primary coverage? ☐ Yes ☐ No

Does the patient have primary coverage under another plan? ☐ Yes* ☐ No

*If yes, please attach an explanation of benefit from your primary carrier.

Prescription Information

Important – All prescription claims must have prescription receipts / labels which includes:

- Patient's Name
- Pharmacy Name
- Pharmacy Address
- Date Filled
- Drug Name, Strength and NDC
- Script number
- Price
- Quantity
- Days supply

Please note that the above claim detail information is necessary in order to process your claim request.

Remember:

- Please tape receipts to separate piece of paper
- Cash register receipts **are not** acceptable for any prescription (with the exception of diabetic supplies).

Diabetic Supply

- Is the claim for diabetic supply? ☐ Yes ☐ No
- Please make sure receipts include:
  - Patient's Name
  - Pharmacy Name
  - Pharmacy Address
  - Date filled
  - Type of insulin and/or type of supply
  - Quantity
  - Days supply
  - Price
- Cash register receipts are acceptable but Pharmacist Signature is required if any information is handwritten.

Diabetic Supply

- Is the claim for allergy serum or vaccination? ☐ Yes* ☐ No

  *If yes, please supply type or additional information.

Continued on next page

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Signature

I certify that all information provided is correct and that the prescription(s) submitted are for me. I have received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc., the company chosen by my Plan Sponsor to manage my pharmacy benefit, and my Plan Sponsor. Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PATIENT'S SIGNATURE _____ DATE _____

Reimbursements can be mailed to:
Pharmacy Services Department
U.S. Steel Tower, Floor 12
600 Grant St.
Pittsburgh, PA 15219