Prescription Claim Payment Form

For claim payment, complete and mail this form to Trillium Community Health Plan Attn: Pharmacy Department, P.O. Box 11740, Eugene, OR 97440-3940. Forms can also be faxed to 844-956-0157. **Incomplete forms will delay processing.** Trillium Member Services can be reached at 1.877.600.5472.

Important

- Keep a copy of all documents submitted for your records
- Payment is not assured; the claims coverage has limitations and exclusions.

To be completed by insured. Please PRINT clearly.

I. MEMBER INFORMATION	II. PRESCRIPTION PLAN INFORMATION
Member Name:	Insured's Member ID #:
Birth Date:__/_____/_____	Phone:
Address:	

III. PATIENT INFORMATION
Relationship to insured: ☐Self ☐Spouse ☐Dependent ☐Other
Coordination of Benefits (COB) Is the medicine covered under any other group insurance? ☐Yes ☐No *If other coverage is Primary, include the Explanation of Benefits (EOB) with this form.
Explanation for the request.

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IV. PRESCRIPTION INFORMATION

This section must be completed by you or your dispensing pharmacist. One prescription label should be attached for each prescription.
****You must also include a copy of your pharmacy receipt with this form.****

Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled:___/____/_____	Quantity:
RX Name & Strength:		Days Supply (30, 60, 90):	
NDC #:	DAW:	Price:	Comments:
Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled:___/____/_____	Quantity:
RX Name & Strength:		Days Supply (30, 60, 90):	
NDC #:	DAW:	Price:	Comments:

Did you receive and sign a Pharmacy Agreement to Pay form (OHP 3166) at the pharmacy?

- ○ **Yes- Please attach a copy**
- ○ **No- by signing below you agree that you did not sign a Pharmacy Agreement to Pay form.**

Important! A signature is required.

Please sign and date here: I certify that the above information is correct and the prescriptions listed above are for myself or eligible members of my family who have received the medication described above, and I authorize release of all information contained on this claim form to pharmacy services and my plan sponsor.

Signature:_____ **Date signed:** _____