

COB PRESCRIPTION CO-PAY REIMBURSEMENT HELP SHEET

FIELD NAME	DESCRIPTION
Subscriber Information	Subscriber is the person: <ul style="list-style-type: none">• who enrolls in US Family Health Plan and signs the membership application form on behalf of him/herself and any dependents.• in whose name the premium is paid.
Patient's USFHP Member Identification #	Member Identification # with suffix, found on the front of the US Family Health Plan Member card.
Patient's Name	Last and First names and Middle Initial of patient who received services.
Patient's Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits).
Prescription Name	Name of the medication as it appears on your pharmacy receipt.
Total Amount Paid	Total amount for which you are requesting reimbursement.
Receipt from Pharmacy	You must include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will <u>only</u> be accepted for diabetic supplies.