



**UTICA COMMUNITY SCHOOLS- NEW PLAN YEAR
Pharmacy Copay Reimbursement Form**

Note for Section 125 subscribers: Check IRS regulations for eligibility of non-reimbursed medical expenses under your section 125 account.

Member Section (PLEASE PRINT CLEARLY)

Plan Year: 7/1/2009 Thru 06/30/2010

Cardholder Name:	_____	_____	_____
	(Last)	(First)	(Middle)
Cardholder Address:	_____		
	(address)		
	_____	_____	_____
	(City)	(State)	(Zip Code)

Patient Information

Name:	_____	_____	_____
	(Last)	(First)	(Middle)
Date of Birth:	_____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Relationship to Member:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant		
Phone Number:	_____	_____	_____
	(Home)	(Work)	(Alternate)

Claim Information

Date of Service	Prescription Number	Drug Name	Reimbursement Type (*MSB;**SSB;***STD)

***Multi-Source Brand (MSB):** The physician requires a brand name drug be used instead of the generic for therapeutic reasons.
 ****Single-Source Brand (SSB):** The prescription is for a brand name drug for which there is no generic available
 *****Step Therapy Denial (STD):** The physician requires a Brand name drug in lieu of a generic for therapeutic reasons and your primary insurance denies the claim. (Copy of DRAMS denial letter, Exception Form and pharmacy receipt is required for each prescription.)

Please send completed form, pharmacy receipt (not a cash register receipt) and if required, DRAMS Exception and Denial forms to: Submission of claims must be within 45 days of the end of the plan year. EHIM Reimbursement Department, 26711 Northwestern Highway, Suite 400, Southfield, Michigan 48033

Important! Please read and sign below:

Cardholder Certification: I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I certify that all the information entered on this form is correct. By signing below I have exhausted all remedies through your primary insurance. Rejection Forms must be submitted. Any person who knowingly and with intent to defraud any insurance company or files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Cardholder

Date

If you should have any questions regarding the reimbursement process, please call the EHIM Medical Department at 248-948-9900.

Privacy Statement: The information on this form is legally privileged and confidential information intended for the use of the individual(s) named above. If you, the reader of this form, are not the intended recipient, you are hereby notified that you should not further disseminate, distribute, or forward this form. Thank you!