AdventHealth
Advantage Plans

6450 U.S. Highway 1
Rockledge, FL 32955
myAHplan.com

Commercial Member Prescription Drug Reimbursement Form

This form is required when submitting all requests for prescription drug reimbursement. Please submit a separate form for each patient.

Instructions: In addition to this form, we also require that you enclose either the original attached receipt that was on your medication bag at the time of purchase or a full printout of your claim details from your pharmacy. Your claim(s) cannot be processed if any of the following information is missing:
● Medication name ● Quantity ● Day supply ● 11-digit NDC number ● Fill date ● Prescribing physician ● Pharmacy information ● Patient amount paid

Member Information

Required

Member Name: ______________________________

Member ID Number: ______________________________

Phone Number: (________)______________________________

Member Address: ______________________________
Street Address

______________________ ________ ________
City State ZIP

Medication Information

Required

Medication Name(s): ______________________________

Prescription Number(s): ______________________________

Number of Prescriptions submitted: ____________

Mail to: AdventHealth Advantage Plans
Pharmaceutical Services Department
6450 U.S. Highway 1
Rockledge, FL 32955

Fax to: 855.328.0061

Please select one of the following reimbursement request reasons:

□ Did not have AdventHealth Advantage Plans member ID card at time of purchase
□ Vacation supply
□ Prescription(s) obtained prior to an eligibility update (COBRA, FHICCA, etc.)
□ Out-of-network purchase; please attach a detailed explanation on the next page
□ Other; please attach a detailed explanation on the next page

IMPORTANT INFORMATION ABOUT YOUR SUBMITTED CLAIM(S)

- Prescription reimbursement claims must to be submitted within 180 days of the fill date.
- Claims for non-covered or non-authorized medications will not be reimbursed.
- In covered instances, we will reimburse you at the contracted pharmacy rate minus your prescription drug copay (if applicable). Please note that the amount you paid may be higher than our contracted pharmacy rate.
- Claim forms submitted without the required information may cause a delay in payment or may be returned to you. (Example: a cash register receipt alone does not contain the required information).
- Approved reimbursement requests will receive payment within four to six weeks from the date the claim was processed (if applicable)
- Denied reimbursement requests will receive a notice of denial to explain the denial reason.
- Reimbursement requests when a *discount card* was used cannot be processed with insurance and any amounts paid out of pocket will not apply toward your deductible or max out-of-pocket accumulators.

If you need further assistance, call Customer Service toll-free at 1.844.522.5279 (TTY/TDD relay: 1.800.955.8771) Monday through Friday from 8 a.m. to 6 p.m. If you call after hours, you can leave a message and we will return your call the next business day.

Detailed Explanation for Reimbursement Request

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Health First Commercial Plans, Inc. is doing business under the name of AdventHealth Advantage Plans. AdventHealth Advantage Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

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