SBMA

Prescription Drug Claim Form

This form is to be used for reimbursement of covered preventative prescription drugs only. The Basic MEC plan does not include prescription drug coverage with the exception of preventive drugs as mandated by the Affordable Care Act (ACA). Preventative drugs are covered at, and will be reimbursed at, 100%.

Please complete this form and include a copy of your original payment receipt and proof of your prescription which may be a copy of the prescription or a copy of the prescription profile supplied by your pharmacist. **SBMA will not process your claim if you do not include these items.**

Date Submitted: _____

Number of Prescriptions Attached: _____

PART ONE: Member Information

Member Name: _____

Member Number: _____ Daytime Telephone Number: _____

Mailing Address: _____

PART TWO: Claimant Information *(Please use a separate form for each family member.)*

Claimant's Name: _____

Claimant's Date of Birth (MM/DD/YY): _____

Patient is: ☐ Male ☐ Female / ☐ Member ☐ Spouse ☐ Child

☐ Check if partial coverage was provided by another insurance policy. If checked, please attached Explanation of Benefits (EOB) from the other policy provider.

The undersigned certifies that the prescription receipts attached herein were received by the undersigned for the member noted above, who is eligible for preventative prescription drug benefits, and that such prescriptions were not for an on-the-job Injury or covered under any other benefit plan. The undersigned authorizes release of any and all information to the plan administrator, underwriter, sponsor, policy holder, employer and their agents for use in connection with the benefit plan program. Information may also be used for other reporting and analysis purposes without identification of the undersigned or the member noted above. The undersigned further authorizes use of such person's member number for identification purposes and further recognizes that reimbursement will be paid directly to the member and assignment of these benefits to a pharmacy or other party is void.

_____

Signature of Patient, Guardian, or Legal Representative

Mail your prescription drug claim form and copy of receipt to:

SBMA
Attention: Member Claims
2307 Fenton Pkwy # 107-126
San Diego, CA 92108

Or you email scanned copies of the claim form and receipt to claims@sbmamec.com

Remember to always ask your doctor if a generic drug is right for your condition. If so, ask your doctor to allow your pharmacy to fill your prescriptions with generic drugs. Generic drugs contain the same ingredients as their brand-name counterparts. When you use generic drugs, you get the same quality as brand-name drugs - at a lower cost. If there is no generic available, ask your doctor if a preferred drug is available to treat your condition. **Only Healthcare Reform approved preventive drugs—as outlined in the Affordable Care Act (ACA) will be reimbursed.**