# Out-of-Area/Out-of-Network Pharmacy Reimbursement Request

US FAMILY HEALTH PLAN | TRICARE | CHRISTUS Health

## A. Beneficiary Information

| | |
|---|---|
| *Beneficiary Name: | |
| *Beneficiary Date of Birth: | *Beneficiary ID Number: |
| *Sponsor Name: | *Group Name: |

## B. Service Information

| | |
|---|---|
| *Name of health care provider (physician, facility, pharmacy, etc.) | |
| *Date(s) of service: | *Amount paid for service: |
| *List the illness/injury(s) requiring treatment: | |
| *Was the illness or injury due to an accident? | If yes, date of accident: |
| *Did accident require hospitalization? | If yes, hospital name and address: |
| *Was this a work-related injury/illness? | If yes, name and address of employer: |

## C. Other Health Insurance

| | |
|---|---|
| *Do you have other health insurance coverage? If yes, provide information below: | |
| Insurance Name and address: | |
| Subscriber Name and address: | |
| Subscriber ID number: | Group Number: |

Please sign and date below. If signature is not provided, this claim will be denied as unable to process.

**Print Name:**_____

**Signature:**_____ **Date:**_____

MC4894 **Denotes required field. Determination may be delayed if these fields are not filled out.

## *REIMBURSEMENT OF OUT-OF-POCKET EXPENSES FOR OUT-OF-AREA SERVICES*

If you are traveling outside the service area and require urgent or emergent care, the provider should bill USFHP at the address shown on the back of the Beneficiary ID card. However, some providers (especially if they are outside the United States) may require immediate payment from you.

To obtain reimbursement for out-of-area services as described above, complete this form and submit the required documentation to the address shown below within 365 days of the date of service. Requests submitted after 365 days will be denied.

## *REIMBURSEMENT OF COVERED OUT-OF-NETWORK PRESCRIPTION DRUGS*

Allowable amounts are calculated based upon the participating provider rate as provided by our pharmacy partners. The Point of Service (POS) benefit applies to covered prescription drugs filled at out-of-network pharmacies when prescribed by an authorized US Family Health Plan provider. NOTE: The POS benefit has a higher out-of-pocket cost for covered prescription drugs than if you had chosen an in-network pharmacy. (50% of total cost applies after the POS deductible is met for formulary and non-formulary covered drugs)
To obtain reimbursement for covered out-of-network prescription drugs complete this form and submit the required documentation to the address shown below within 365 days of the date the prescription was filled. Requests submitted after 365 days will be denied.

## *SUBMISSION ADDRESS FOR REIMBURSEMENT*

Submit this completed form and the required documentation within **365 days of the date of service,** at the address indicated below:

**CHRISTUS Health Plan**
Attn: Claims Department
5101 N. O'Connor Blvd.
Irving, TX 75039

## *INSTRUCTIONS TO FILL OUT REIMBURSMENT FORM*

Complete the reimbursement request form as directed below:

1. **Section A:**
   Enter/write Sponsor/Beneficiary Number as printed on the US Family Health Plan Beneficiary ID card.
2. **Section B:**
   Enter/write the name of the physician, facility, pharmacy, or other health care professional from whom you received services; the date of the service; and the amount you paid. Provide as much information as possible. If you need assistance in completing, please call Beneficiary Services at the number on the back of your Beneficiary ID card.
3. **Section C:**
   If applicable, enter/write the name and address of your other health insurance, as well as, the additional requested information for your policy. In the event that you are submitting multiple requests for reimbursement, this section can be filled out only one time unless there is change that needs to be noted.
4. **Attach Evidence of Payment:**
   Attach copy of original receipt or cancelled check **and** a copy of your bill.

***Important Note: If this form and required documents are not included the claim will be denied due to lack of documentation.*** It could take up to 30 days for your request to be uploaded and processed into CHRISTUS systems. (Upload could take even longer if additional research is required for your submission.) Appeals should not be submitted until you receive a determination letter for this service from the plan.

***If you have additional questions regarding your benefits, please contact Beneficiary services at the number on the back of your Beneficiary ID card or review the Beneficiary handbook, which can be accessed online at christushealthplan.org.***