

Health First Health Plans



6450 US Highway 1
Rockledge, FL 32955

Customer Service
Telephone 321.434.5665
Toll-free 800.716.7737
TDD relay 800.955.8771
E-mail hfhpinfo@health-first.org

healthfirstthehealthplans.org

Prescription Drug Reimbursement Form

This form must be used 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 all of the following information is not identified: ● **medication name** ● **quantity** ● **days supply** ● **11-digit NDC number** ● **fill date** ● **prescribing physician** ● **pharmacy information** ● **patient amount paid**.

Member/ Subscriber Information

Required	Member Name:	_____
	Member ID Number:	_____
	Phone Number:	(____) _____
	Member Address:	_____
	Street Address	_____
	City	_____
	State	<input type="text"/> <input type="text"/>
	Zip	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Patient Information

Required	Patient Name:	_____
	Patient ID Number:	_____
	Relationship to Subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
	Number of scripts submitted:	_____

Mail to: Health First Health Plans
Pharmaceutical Services Department
6450 US Highway 1
Rockledge, FL 32955

Fax to: 321-434-4228

Please select one of the following reimbursement request reasons:

- Did not have Health First 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

