Direct Member Reimbursement Form

Revised August 6, 2020

Jackson Care Connect™
Part of the CareOregon Family

Please submit complete forms and attachments to:
Jackson Care Connect: Attention Pharmacy DMR
PO Box 40328 Portland, Oregon 97240-0328 OR,
315 SW 5th Avenue Ste. 900 Portland, Oregon 97201-9922

In order to process your request in the timeliest manner, validate all information on this form is complete and legible. If the decision for reimbursement is favorable you may expect to receive payment after 30 days from the date of receiving a completed request.

You must include one of the following: 1. Copy of prescription labels ***AND*** Proof of payment (register receipt); ***OR*** 2. Pharmacy printout signed by pharmacist with the completed form. Please retain copies for your record(s).

Request must be submitted within 90 days of original date of service. Please select reason(s) for request(s):

◯ Coverage info not available *(within the first 30 days of eligibility)*
◯ Hospital discharge with documentation
◯ Pharmacy out of network for emergency fill
◯ Other: Urgent: _____

Member information

Last name: _____ First name: _____

DOB: _____ Subscriber ID: _____ Gender: _____

Address: _____

City: _____ State: _____ ZIP: _____

Person completing the form

☐ Same as member above ☐ Parent/legal guardian of minor

Name: _____ Phone#: _____

Address: _____

City: _____ State: _____ ZIP: _____

Pharmacy information

Name: _____ Phone#: _____

Address: _____

City: _____ State: _____ ZIP: _____

Requested drug(s) for reimbursement

Date of service*		Qty	Medication name and strength	Day supply	Amount
1					
2					
3					
4					
*Date of service must be within 90 days.				Total:	

Comorbid Conditions

By signing this form below, I certify that all information provided on this form is correct and best of my knowledge; the prescription(s) submitted are for me or members of my family who are eligible and are for the sole use of the named member above. I authorized release of any eligible, contact to the pharmacy and doctor office as necessary to obtain information pertaining to this claims(s) to CareOregon and I understand that fraudulent acts (including false claims) may be subjected to civil or criminal penalties.

Signature: _____ Date: _____

FOR CAREOREGON USE ONLY: ◯ Rec'd: ◯ Completed ◯ Approved ◯ Denied ◯ Cancelled/member ineligible

◯ Eligibility _____ ◯ No duplicate claims ◯ QXNT ◯ DMR LOG ◯ Uploaded to DMS ◯ Processed through RxAuth
◯ Pharmacy labels /Proof of purchase ***OR*** ◯ Pharmacy printout with pharmacist sig ◯ Letter created/cancelled ◯ DMAP
◯ Emailed Catamaran ◯ Manual claim(s) processed through Catamaran: Date: _____ ◯ Secondary only ◯ LOB: _____