

# Direct Member Reimbursement Form

Revised May 14, 2021

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**



**Jackson Care  
Connect™**

Part of the CareOregon Family

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 explain the reason(s) for the request: \_\_\_\_\_  
\_\_\_\_\_

## Member information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Member 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, strength, and form	Day supply	Amount
1				
2				
3				
4				
5				
6				
7				
8				

\*Date of service must be within 90 days.

Total:

## Person completing the form signature

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 claim(s) to CareOregon and I understand that fraudulent acts (including false claims) may be subjected to civil or criminal penalties.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_