tria HEALTH

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Instructions for completing the Tria Health Member Reimbursement Form

All information must be provided in order to accurately process your claim(s). Incomplete or illegible information will result in form being returned or payment delays. If you need assistance completing this form or have questions regarding this reimbursement process, a Tria Health Member Advocate can be reached at 1.888.799.8742.

PLEASE ALLOW TWO - FOUR (2-4) WEEKS FOR PROCESSING

In situations where the pharmacy cannot or will not process your Tria Health incentive, we are happy to process those claims manually based on the guidelines of your plan design.

- The amount of reimbursement received may be less than the member paid at the pharmacy based on a number of variables including plan design, deductibles, co-payments, and discounted price of drug.
- Reimbursements are available as long as the Tria Health benefit is active through your employer.
- Reimbursements cannot be processed if the prescription fill date is greater than 12 months from the time the reimbursement is submitted.

MEMBER INFORMATION

- **Member Name:** Enter the person for whom the prescription was written. This is either the cardholder or the spouse/dependent of the cardholder
- **Date of Birth:** Enter the birth date of person for whom the prescription was written.
- **Cardholder ID:** Enter the member Identification Number assigned to you by Tria Health.
- **Address:** Enter permanent mailing address.
- **Contact info:** Provide e-mail address and daytime phone number.

PRESCRIPTION INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information.
Please Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234 (509)555-1234
123 Any Street **Store NPI: 1234567890**
Home Town, US 12345-6789

RX 1234567 **Date Filled: 1/1/2022**

DOE, JANE
DOB: 01/01/1972
456 Home Road (509)555-5678
Home Town, US 12345

LISINOPRIL 40MG TAB SOL **DAW: 0**
43547-0356-10 QTY: 45 **Days Supply: 30**

A. SMITH, MD
NPI: 4567890123

U&C: 200.00 **COPAY: 20.00**

1. Date Filled*
2. Rx Number
3. Quantity*
4. Day Supply*
5. National Drug Code (NDC)*
6. Medication Name and Strength*
7. Physician Name
8. Physician National Provider ID (NPI)
9. DAW
10. Usual and Customary Price (U&C)/Rx Price*
11. Copay*
12. Pharmacy National Provider ID (NPI)

**REQUIRED INFORMATION - CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED.*

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PLEASE ALLOW TWO - FOUR (2-4) WEEKS FOR PROCESSING.

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Member Name: _____ **Date of Birth:** _____

Cardholder ID Number: _____

Member Mailing Address: _____

_____

You will be notified by e-mail when we have received and processed your claims.
This e-mail will not contain any personal health information or drug names.

Email Address: _____ **Phone Number:** _____

We will only contact you by phone should we need more information in order to process your reimbursement request.

Total number of individual prescription claims you are submitting for reimbursement: _____

IMPORTANT: You must submit a Pharmacy receipt or a Pharmacy printout for each claim that includes:

Name, address, and phone number of pharmacy; date prescription was filled; prescription number; NDC number; drug name and strength; quantity; days supply; and the dollar amount you paid to the pharmacy.

If you are submitting on-line you must attach either a photo or scanned file of your receipt(s) when submitting this form.

IMPORTANT: Failure to provide all the above information will delay the processing of your claims

It is to your advantage to have the pharmacy submit the claims on-line to Tria Health whenever possible. Provide the reason(s) your pharmacy did not submit the claims directly to Tria Health:

- ☐ I did not have my Tria Health Incentive Card.
- ☐ The pharmacy could not, or would not, submit the claim directly to Tria Health.
- ☐ Other (please explain): _____

Unless the member is a minor (17 or younger) this form must be signed by the person for whom the prescriptions were written, otherwise the Cardholder must sign. **By signing below, I certify the above information is correct.**

Member Signature: _____ **Date:** _____

You can mail completed form to:
Tria Health
Attn: Keyed Claims Dept.
7101 College Blvd., Ste. 600
Overland Park, KS 66210

You can fax completed form to:
Tria Health
Attn: Keyed Claims Dept.
Fax Number: 913-322-8497

You can email completed form to:
Tria Health
reimbursements@triahealth.com