

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

Date Filled: 1/1/2022

RX 1234567

Date Fitted. 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

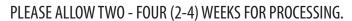
A. SMITH, MD NPI: 4567890123

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.

Tria Health Member Reimbursement Form



Overland Park, KS 66210



Member Name:		_ Date of Birth:
Cardholder ID Number:		
,	when we have received and proces y personal health information or d	
Email Address:	Phone Nu	ımber:
We will only contact you by phone sh	ould we need more information in order to	process your reimbursement request.
Total number of individual pre	escription claims you are submittin	g for reimbursement:
Name, address, and phone number of and strength; quantity; days supply; a	nd the dollar amount you paid to the phar	escription number; NDC number; drug name
IMPORTANT: Failure to provide al	ll the above information will delay the	e processing of your claims
Provide the reason(s) your pharm I did not have my Tria Health Inc The pharmacy could not, or wou	e pharmacy submit the claims on-line nacy did not submit the claims directly tentive Card. Submit the claim directly to Tria He	y to Tria Health:
Other (please explain):		
	unger) this form must be signed by the per signing below, I certify the above inform	son for whom the prescriptions were written, ation is correct.
Member Signature:		Date:
You can mail completed form to: Tria Health Attn: Keyed Claims Dept. 7101 College Blvd., Ste. 600	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