TRIPLE-S ADVANTAGE

Prescription Drug Reimbursement Form

In order to process your request as timely as possible.

- *The pharmacy's original invoice/receipt is required.*
- We suggest that you include a copy of the prescription to speed up the process and complete the prescription Reimbursement Form.
- If necessary, you may complete more than one claim reimbursement form.
- ***We recommend that Section 2 & 3 must be completed by pharmacies, given that certain information may not appear on the pharmacy invoice.***

You must mail this form to the Triple-S Advantage to the following address:

Triple-S Advantage, Inc.
Pharmacy Department
PO Box 11320 San Juan, PR 00922
Fax: 787-993-3262

Your request will be processed within 14 calendar days.

Section 1 – Beneficiary Information			
Name:		Plan Member ID Number:	
Date of Birth:	_____/_____/_____ (mm/dd/yyyy)	Gender: ☐ Male ☐ Female	Phone:
Address:_____City:_____ State:_____Zip Code:_____			
Are you enrolled in another health plan that may cover the prescription drug? ☐Yes ☐ No		If you answered "yes," please indicate whether the other health plan coverage is: ☐ Primary ☐ Secondary	
Name of your other health plan:_____		Other Plan Member ID Number: _____	
Section 2 – Pharmacy Information			
Name:		Phone:_____NPI# :_____	
Address:_____City:_____ State:_____Zip Code:			
Pharmacist Signature:			
Section 3 – Drug Information *(pharmacy should fill out this information)*			
Drug #1 ☐ New Prescription ☐ Refill #__of___		**Drug #2** ☐ New Prescription ☐ Refill #__of___	
Service Date:_____/____/_____ Prescription Date:_____/____/_____		Service Date:_____/____/_____ Prescription Date:_____/____/_____	
Prescription Number		Prescription Number	
Quantity Dispensed		Quantity Dispensed	
Days' Supply		Days' Supply	
Drug Name		Drug Name	
Drug NDC #		Drug NDC #	
Prescribing Physician NPI or DEA #		Prescribing Physician NPI or DEA #	
Amount Paid: By You		**Amount Paid: By You**	
Amount Paid: Other Plan		**Amount Paid: Other Plan**	

Member Signature: _____ **Date:** _____

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ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: 1-888-620-1919 (TTY: 1-866-620-2520). ATENCIÓN: Si usted habla español, servicios de asistencia lingüística están disponibles libre de cargo para usted. Llame al: 1-888-620-1919 (TTY: 1-866-620-2520). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-620-1919 (TTY: 1-866-620-2520）。