

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:
Address: _____ City: _____ State: _____ Zip Code: _____			
Are you enrolled in another health plan that may cover the prescription drug? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you answered “yes,” please indicate whether the other health plan coverage is: <input type="checkbox"/> Primary <input type="checkbox"/> 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 <input type="checkbox"/> New Prescription <input type="checkbox"/> Refill #__of__		Drug #2 <input type="checkbox"/> New Prescription <input type="checkbox"/> Refill #__of__	
Service Date: ____/____/____		Service Date: ____/____/____	
Prescription 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: _____

Triple-S Advantage, Inc. complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. Triple-S Advantage, Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina por razón de raza, color, origen de nacionalidad, edad, discapacidad, o sexo. Triple-S Advantage Inc. 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人

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)。