US Roche Product Reimbursement Program Claim Form

Part 1: About you

For faster payment, please complete this section.

Date to be entered MM/DD/20YY

Your name (Last, First, MI)

Employer:

Roche PRA Policy# 906566

You can find these two numbers on your Health Plan ID Card or your member website.

Last four digits of your Social Security #: ☐☐☐☐

Your Group Number: 906566

Your Date of Birth: ☐☐/☐☐/☐☐☐☐

Your mailing address (street address, city, state, ZIP)

Part 2: About your expenses

Complete the information below for each expense you're submitting.
If you have more than three expenses, please print out multiple copies of this page and use this section as many times as needed.

1 Expense 1

Information must match your receipt.

Date to be entered MM/DD/20YY

Date of purchase: ☐☐/☐☐/20☐☐

Amount: ☐,☐☐☐.☐☐

Patient name

This is (check one):
- ○ Myself
- ○ My spouse
- ○ My dependent

Product name, NDC or Material #:

2 Expense 2

Information must match your receipt.

Date to be entered MM/DD/20YY

Date of purchase: ☐☐/☐☐/20☐☐

Amount: ☐,☐☐☐.☐☐

Patient name

This is (check one):
- ○ Myself
- ○ My spouse
- ○ My dependent

Product name, NDC or Material #:

3 Expense 3

Information must match your receipt.

Date to be entered MM/DD/20YY

Date of purchase: ☐☐/☐☐/20☐☐

Amount: ☐,☐☐☐.☐☐

Patient name

This is (check one):
- ○ Myself
- ○ My spouse
- ○ My dependent

Product name, NDC or Material #:

Need help?
Call us at 1-888-264-0749

Please continue the form on the next page.

Part 3: Attach your receipts or Explanation of Benefit forms

Now it's time to attach the papers that confirm the expenses. These can include the receipts from health care services and Explanation of Benefit (EOB) forms.

Provide an itemized receipt for each amount requested, or your request will be denied.

Please don't send credit card receipts, cashed checks or copies of checks. They are not acceptable receipts for reimbursement.

The papers you provide as proof for your expenses **must** show specific information:

For Roche Products:

- ○ Patient's name
- ○ Amount charged
- ○ Date the prescription was filled
- ○ The National Drug Code (NDC) number or Material Number
- ○ One of these:
  - ▶ Name of medication or product
  - ▶ The word 'co-payment' printed on receipt

1. Circle names and dollar amounts on your receipts. Don't write any information on the receipt.
2. Use only blue or black ink. Don't use a highlighter.
3. Tape small receipts to a sheet of 8.5 x 11 blank white paper.

Part 4: Certify and sign

Please reimburse me for the expenses I am submitting on this form.
By signing below I certify (promise) that:

- ▶ The expenses I am submitting were spent by me or my spouse or eligible dependents;
- ▶ These are eligible expenses;
- ▶ These expenses have not been reimbursed before, and I will not ask for reimbursement from any other account;
- ▶ These expenses have not and will not be claimed as a federal income tax deduction or credit; and
- ▶ To my knowledge, the statements I have made on this form are true and complete.

Sign here

_____

Date

☐☐ / ☐☐ / 2 0 ☐☐

Date to be entered MM/DD/20YY

Mail or fax pages 1 and 2 of this form along with your receipts

Mail to: Health Care Account Service Center
P.O. Box 740378 Atlanta, GA 30374

▶ Fax: (248) 733-6148 ▶ Toll-free fax: 1-866-262-6354

Copy your form and receipts for your records before mailing.

Need help?
Call us at 1-888-264-0749

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