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 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

- Please indicate the total number of individual prescriptions you are submitting for reimbursement. This number should be the same number of attached receipts and/or line items on a printout.
- Most Pharmacies supply a receipt for each individual prescription which includes the required information. If you have lost a receipt, or have multiple claims, the Pharmacy can supply you with a printout of prescriptions for a given time period. Either the receipt or the printout will be sufficient if it provides the following information:
    1. The name, address, and phone number of the pharmacy.
    2. The date the prescription was filled.
    3. The number assigned to the prescription by the Pharmacy (prescription number).
    4. The National Drug Code (NDC), which identifies the drug product dispensed.
    5. The name and strength of the drug dispensed.
    6. The quantity of the product dispensed.
    7. The number of days the dispensed quantity is expected to last.
    8. The dollar amount the member paid the Pharmacy for the prescription.
- **Cash register receipts do NOT have the information required to process a claim.**

TRIA HEALTH MEMBER REIMBURSEMENT FORM

Please allow two to four (2-4) weeks for processing.

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.

My e-mail address is: _____

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

My daytime phone number is: _____

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. Suite 600
Overland Park, KS 66210

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

You can submit completed form on-line:
Tria Health
reimbursements@triahealth.com