AULTCARE'S PRIMETIME HEALTH PLAN

REIMBURSEMENT FORM

Name of Person Filing Reimbursement _____

Relationship to Covered Person ☐ Covered Person/Applicant

☐ Authorized Representative *(please complete the Appointment of Authorized Representative section)*

CONTACT INFORMATION OF AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Mailing Address	City	State	Zip Code
Daytime Phone		Evening Phone	
Email Address		Fax	

COVERED PERSON/APPLICANT INFORMATION

First Name	Last Name	Member ID Number	
Mailing Address	City	State	Zip Code
Daytime Phone		Evening Phone	
Email Address		Member Date of Birth	

Provider/Pharmacy Name _____

Date of Service or Purchase _____

Amount Paid by Member _____

Please Provide a copy of proof of payment and an itemized statement with this request

Check Boxes for: TYPE OF REIMBURSEMENT

☐ Part D Pharmacy ☐ Self-Administered Drugs ☐ Hearing ☐ Vision ☐ Dental ☐ Other: _____

For possible reimbursement, please send us your itemized receipts (they do not need to be in English) and proof of payment. If this is a request for medication reimbursement, please include drug name(s), an itemized receipt with the drug name(s), quantity, days supply and NDC (National Drug Codes). Please be advised, you must submit your request to PrimeTime within 12 months of the date you received the service, item or drug. Reimbursement is based on Medicare Allowable Rates. Applicable copays or coinsurance will be subtracted from reimbursement (when applicable).

Please mail this form along with a copy of your itemized statement and proof of payment to this address:
PrimeTime Health Plan P.O. BOX 6905 Canton, OH 44706