commonwealth care alliance®

HEALTHY $AVINGS OVER-THE-COUNTER (OTC) REIMBURSEMENT FORM

Commonwealth Care Alliance®'s Senior Care Options (SCO) program provides an allowance every calendar quarter toward Medicare-approved OTC items. The amount of the allowance may vary from year to year. See the third page of this document for a list of examples of covered and non-covered items. Please note that your Healthy Savings card will be automatically refilled at the start of every calendar quarter (January 1, April 1, July 1, and October 1). Approved reimbursement for covered items will be deducted from the card balance based on date of purchase. To **submit** a request for reimbursement, please follow the instructions below and complete this form and all of its pages. Documentation of your purchases must be submitted by including a copy of your receipt(s) that show the date of purchase or service.

Please check which service you are requesting reimbursement for:

☐ **Healthy Savings** ☐ **Over-the-counter purchase with prescription** (OTC)

Required Information

Last Name: _____ First Name: _____ Middle Initial: __

Member ID #: _____ Date of Birth: ____ / ____ / _____

(M M / D D / Y Y Y Y)

Name of Retailer (such as CVS Pharmacy, Walgreens, etc): _____

_____

Date(s) of Purchase: _____

If additional information is necessary, please use another sheet of paper and submit it with this form.

Total amount of reimbursement requested: $ _____

Describe the purchase to be reimbursed:

_____

_____

Please include an itemized receipt as proof of payment. Please **circle** the items on the receipt for which you are requesting reimbursement.

A receipt is required for purchased items, with the retailer's name and address preprinted on the receipt, with items listed and the amount paid.

Submission Method

To submit your request for determination, please send:

By mail: Commonwealth Care Alliance, Attn: Member Services, 30 Winter Street, Boston, MA 02108
By fax (617) 426-1311
By email memberservices@commonwealthcare.org

Signature is Required

I attest that the information is accurate and complete.

Signature:_____Date:_____