SAN FRANCISCO HEALTH PLAN
Here for you

Pharmacy Department
P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
sfhp.org

Pharmacy Reimbursement Request Guidelines

Requests for reimbursement of pharmacy services are subject to review by SFHP pharmacy staff. SFHP Evidence of Coverage, plan exclusions and formulary guidelines apply to reimbursement requests. Submission of requests for reimbursement does not guarantee that your request will be fulfilled. Please note that it may take up to 30 days to process your request.

All reimbursement requests must be submitted by fax or mail and must include a written reason explaining why you paid out of pocket for your prescription along with pharmacy cash register receipts, pharmacy label leaflets with barcode or pharmacy printout, with the price and the following information:

Member Name	SFHP ID#	Date of Birth	Today's Date
Current Street Address	City	State	Zip code
Name of medicine	Quantity	Prescriber	Amount Paid
Pharmacy Name	Pharmacy Address	Pharmacy Phone Number	Date of Service
For members who are minors, please include the name of a parent or a legal guardian to whom the check should be issued to:			

Submission check list: (all items must be included for consideration of reimbursement)

- ☐ Cash register receipt from pharmacy, showing the amount paid out-of-pocket,
- ☐ Pharmacy label leaflets with barcode, or pharmacy printout, with your name, address, drug name, and dispensing date.
- ☐ Written reason explaining why you paid out of pocket for your prescription (please use the space provided on the next page)

Requests missing these items will be considered incomplete and reimbursement will not be issued.

If you need assistance to translate this letter in another language, please contact San Francisco Health Plan at 1(800) 288-5555.

Si necesita ayuda para traducir esta carta a otro idioma, comuníquese con San Francisco Health Plan al 1(800) 288-5555.

若您需要將此函翻譯成其他語言，請聯絡 San Francisco Health Plan，電話 1(800) 288-5555。

Nếu quý vị cần hỗ trợ dịch thư này sang một ngôn ngữ khác, vui lòng liên lạc San Francisco Health Plan theo số 1(800) 288-5555.

Если Вам нужна помощь с переводом этого письма на другой язык, пожалуйста свяжитесь с San Francisco Health Plan по телефону 1(800) 288-5555.

Kung kailangan ninyo ng tulong para maisalin ang sulat na ito sa ibang wika, pakikontak ang San Francisco Health Plan sa 1(800) 288-5555.

Please mail complete requests to:
San Francisco Health Plan
Attn: Pharmacy Department
P.O. Box 194247
San Francisco, CA 94119-4247

Or fax requests to:
1(415) 547-7819
Attn: Pharmacy Department

If you have any questions, please contact San Francisco Health Plan Customer Services toll free at 1(800) 288-5555 or 1(415) 547-7800. Thank you for your cooperation.

Please use this space to briefly explain why you paid out of pocket for your medicine:

If you have any questions, please contact San Francisco Health Plan Customer Services toll free at 1(800) 288-5555 or 1(415) 547-7800. Thank you for your cooperation.

If you are hearing impaired, please call the TDD/TTY line at 1(415) 547-7830, toll-free at 1(888) 883-7347 or through the California Relay Service at 711. You may request this document in alternative formats like Braille, large size print, and audio. To request other formats, or for help with reading this document and other SFHP materials, please call Customer Service at 1(415) 547-7800 or toll-free at 1(800) 288-5555.