

**CLAIM FOR REIMBURSEMENT OF  
COSTS FOR PRESCRIPTION CONTRACEPTIVES**

I, \_\_\_\_\_, hereby certify that I was enrolled in the QCHP  Health Alliance HMO  PersonalCare  Health Alliance Illinois  OSF Healthplan  OSF Winnebago  PersonalCare East  State of Illinois health care coverage (check whichever applies) for 2000  2001  2002  2003  2004  (check whichever applies) and that I had incurred out-of-pocket costs for prescription contraceptive drugs, devices or procedures that I purchased during the period of August 31,2000, to June 30, 2004, for my personal use.

Last Name

First Name

Middle Initial

Former Last Name (complete only if name was different at time cost incurred)

First Name

Middle Initial

Street Address

Street Address 2

City

     -

State

Zip Code

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Phone Number

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Social Security Number

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Date of Birth (DD/MM/YYYY)

E-Mail Address (Optional)

My total out-of-pocket cost for prescription contraceptive drugs, devices or procedures during the period August 31, 2000, to June 30, 2004, is as follows:

Type	Out-of-Pocket Cost	Inclusive Dates
<input type="checkbox"/> Pill		
<input type="checkbox"/> Diaphragm		
<input type="checkbox"/> Patch		
<input type="checkbox"/> Implant		
<input type="checkbox"/> IUD		
<input type="checkbox"/> Injection		
<input type="checkbox"/> Other		

Total:

I have attached to this claim form pharmaceutical receipts or records and/or my treating physician's statement as support for each claim for reimbursement listed above. I authorize the dissemination of all information I submit on this form, and any information I include as a supplement to this form, to the courts, all party counsel, the third party administrator, and the appropriate state agency in furtherance of the administration of each claim for reimbursement. For purchases of prescribed contraceptive drugs or devices where I do not have and cannot obtain pharmaceutical receipts or records, I have attached my prescribing physician's statement certifying that such drugs or devices had been prescribed during the relevant period. I certify that the information contained on this form is true and correct to the best of my knowledge, information and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**NOTE: This form must be submitted in order to obtain reimbursement.**

**PHYSICIAN STATEMENT IN SUPPORT OF CLAIM  
FOR CONTRACEPTIVE PRESCRIPTION REIMBURSEMENT**

I, \_\_\_\_\_, hereby certify that I prescribed the following  
contraceptive drugs or devices to \_\_\_\_\_, during the period  
August 31, 2000, to June 30, 2004.

Type	Date	Date	Date	Date	Date
<input type="checkbox"/> Pill					
<input type="checkbox"/> Diaphragm					
<input type="checkbox"/> Patch					
<input type="checkbox"/> Other**					

\* If additional space is needed, you must use an additional form.

\*\* If you checked "other" you must list the medication prescribed:

I certify that the information contained on this form is true and correct to the best of my  
knowledge, information and belief.

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
National Provider Identifier

\_\_\_\_\_  
Physician Signature

Clinic/Office Name and Address:

**This form must be submitted as a supporting document with your completed "Claim for Reimbursement of Costs of Prescription Contraceptives" if you do not have receipts or other proof of payment.**