



## HSA-Qualifying Prescription Form

Participant: Use this form to submit prescription-drug claims when you or your dependents have coverage under the HSA-Qualifying Plan. Claims will not be applied toward your deductible/co-insurance unless you submit them.

MUST MEMBER-SUBMIT PRESCRIPTIONS		
<b>Member (patient) Information</b>	Name:	
	Member ID Number: <i>Please include full member ID (e.g., xxxxxxxx-01)</i>	
<b>Expenses Submitted in the Amount of:</b>	\$ _____	

**Instructions:**

1. Fill out the section above to provide information about your prescription coverage. **If submitting pharmacy receipts for more than one patient, complete a separate sheet for each.**
2. Attach pharmacy receipts for each purchase. The receipts must include:
  - ▶ The name of the drug
  - ▶ Whether the drug is “generic” or “brand”
  - ▶ The full retail cost *and* the cost to you after your discount.
3. Mail all documents to:

First Choice Health—MUST  
P.O. Box 12659  
Seattle, WA 98111-4659

**DISCOUNT PHARMACY CARD BENEFIT**

Prescriptions may be purchased at a discounted rate from network pharmacies. Prescription drugs must be paid for at the point of purchase then submitted to the Medical Plan for reimbursement. The annual deductible applies and charges are subject to co-payments (where applicable) until satisfaction of the Out-of-Pocket Maximum. MUST reimburses the contract cost of the prescription drug less the applicable co-payment per prescription.