



910 W Van Buren, 6th Floor
Chicago IL 60607
Phone: 312-491-1956
Fax: 312-491-1175

Dear Family Health Network Member,

Most of your medications are free when you show your HFS Medical Card at the pharmacy. But, sometimes you may have to pay a small amount ranging from \$2 to \$5 for prescription co-pay. **Family Health Network will refund that money to you!** Use this checklist to make sure you qualify for a prescription reimbursement.

- **Co-pays will be between \$2 and \$5 ONLY**
- **Prescription must be covered by HFS**
- **Present your state-issued medical card when getting a prescription (NOT your FHN ID Card)**
- **Make sure you SEND YOUR CO-PAY RECEIPT along with the completed claim form to FHN**

If you meet all the requirements above, please fill out the reimbursement form below. Send the form and your co-pay receipt to Family Health Network. When we receive the form and receipt, we will send the co-pay reimbursement to the address on the form. Please make sure your contact information is correct.

Questions? Call Member Services at: 1-888-346-4968

Sincerely,

Family Health Network

Family Health Network

** Please use only one form for each family member. If you need more reimbursement forms, please call Member Services.*

*~ Family Health Network Prescription Reimbursement Form ~
(Forma de Reembolso de Prescripciones de Family Health Network)*

Name (Nombre): _____ Birth Date (Fecha de nacimiento): _____

Recipient ID (Recipiente ID): _____

Case Holder (Administrador de Caso): _____

Address (Dirección): _____ Apt (No. de Departamento): _____

City (Ciudad): _____ State (Estado): _____ Zip (Código Postal): _____

Phone Number (Número de teléfono): _____

Send To:
Family Health Network
910 W. Van Buren, 6th Floor
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*** Attach your original pharmacy receipt and mail it to Family Health Network.
*** Adjunte su recibo original de la farmacia y envíelo a Family Health Network.