MEMBER REQUEST FOR PHARMACY REIMBURSEMENT FORM

Please use one form for each health expense you are asking Alameda Alliance for Health (Alliance) to reimburse to you. Complete all sections of the form and attach the required documents listed below. The Alliance cannot accept requests that are missing the required documents.

<table>
<tr><th colspan="4">Section A: MEMBER INFORMATION</th></tr>
<tr><td>Last Name:</td><td colspan="2">First Name:</td><td>Middle Initial:</td></tr>
<tr><td>Relation to Member:
☐ Self ☐ Spouse ☐ Son ☐ Daughter</td><td>Authorized Representative Name:</td><td>Sex:
☐ M ☐ F</td><td>Date of Birth: (MM/DD/YYYY)</td></tr>
<tr><th colspan="4">Section B: MEMBER/AUTHORIZED REPRESENTATIVE’S CONTACT INFORMATION</th></tr>
<tr><td colspan="4">Alliance Member ID:</td></tr>
<tr><td colspan="4">Street Address (please include Apt/Unit Number):</td></tr>
<tr><td colspan="2">City:</td><td>State:</td><td>ZIP Code:</td></tr>
<tr><td colspan="2">Home Phone:</td><td colspan="2">Cell Phone:</td></tr>
<tr><th colspan="4">Section C: WHAT TO SUBMIT WITH THIS FORM</th></tr>
<tr><td colspan="4">What to submit: Complete this form and provide the pharmacy label or pharmacy medication pamphlet which you can obtain from the pharmacy. Please also provide proof of payment (such as a receipt). As a reminder, the Alliance cannot accept requests that are missing information.

When to submit: We will accept and review requests that we receive within 180 calendar days after the date the medication was paid for. We cannot accept requests more than 180 days after the date the medication was paid for.</td></tr>
<tr><th colspan="4">Section D: CERTIFICATION</th></tr>
<tr><td colspan="4">I certify that, to the best of my knowledge, the information on this Member Request for Reimbursement Form and supporting documents provided is true and correct.</td></tr>
<tr><td>Signature:</td><td colspan="2">Print Name:</td><td>Date:</td></tr>
</table>

<table>
<tr><th>SUBMIT YOUR REQUEST</th></tr>
<tr><td>Mail this completed request form with the required documents to:
Alameda Alliance for Health
ATTN: Grievance & Appeals Department
P.O. Box 2818
Alameda, CA 94501-0818

If you have questions, contact the Alliance Member Services Department at 1.510.747.4567
People with hearing and speaking impairments (CRS/TTY): 711/1.800.735.2929</td></tr>
</table>