MEDICARE PART D CLAIM FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. Please print clearly. Additional information and instructions on back, please read carefully.

Member ID (see ID card)			Health Plan Name				
Group/Employer Name			Health Plan State				
Last Name			First Name	MI			
Mailing Street Address				Apt. #			
City State	ZIP		Date of Birth (mm/dd/yyyy)				
Physician and Pharmacy Informa	tion						
Prescribing Physician Name			Pharmacy Name				
Prescribing Physician Phone Number w	rith Area Co	Pharmacy Phone Number with Area Code					
Reason for Request							
Filled not using a prescription ID card	☐ YES	□ NO	Filled at a non-network pharmacy:				
Covered under another health plan	☐ YES	□ NO	Illness while traveling outside of				
• If yes, is this other plan Primary	☐ YES	□ NO	service area	☐ YES			
 If primary, include the explanation of benefits (EOB), primary health plan name: 			Network pharmacy/mail order pharmacy within reasonable driving distance could pot fill in a timely manner. The property of the property	☐ YES			
 See section C on back of form – Coordination of benefits 			 not fill in a timely manner While a patient at a health care facility (emergency dept., provider clinic, 	□ YES	□ NC		
My pharmacy billed the wrong plan	☐ YES	□ NO	outpatient surgery)	☐ YES			
A compound prescription (Pharmacist must fill out Section B on back of form)	☐ YES	□NO	Due to federal or state emergency/ natural disaster	☐ YES	□ NC		
Retroactively enrolled with the plan	☐ YES	□ NO					
Filled while waiting for drug approval	☐ YES	□ NO					
t D Vaccine(s)							
Vaccine received at: ☐ Pharmacy ☐ Doctor's office			Vaccine administered at: ☐ Pharmacy ☐ Doctor's office Claim applies to: ☐ Administration cost ☐ Vaccine cost				
Other (places avalain)							
Other (please explain)							
Acknowledgement							
is for the sole use of the named patient for payment under a no-fault automob	I also certif ile or worke	fy that th r's comp	ered in this prescription drug program and the ne claim(s) being submitted for payment are ensation insurance program. I also authorize ator, underwriter, sponsored policy holder, ar	not eligible release of	all		
x							
Member or Authorized Represen	tative Sign	ature	 Date				
NOTE: If form is completed and sign							
the member, an Authorization of Re	presentation	n (AOR)	must accompany the request				



Instructions for Submitting Form

- 1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in Section A (below). If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
- 2. Read the Acknowledgement (section 4) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
- 3. Send completed form with pharmacy receipt(s) to: Claims Department, PO Box 650287, Dallas, TX 75265-0287.
- 4. Do not submit a reimbursement request if:
 - Your prescription claim has already been paid by the plan.
 - Your Part D plan copays or costs applied to your deductible.
 - You have been told the claim processed in the coverage gap.

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Section A – Pharmacy Receipts for Reimbursement												
Use the following checklist to ensure your rece ☐ Date prescription filled ☐ Name and address of pharmacy ☐ Prescribing physician name or ID number	eipts have all infor National Drug Name of drug	ment request: ription number (Rx number) tity										
Section B – Pharmacy Informatio (Pharmacist must complete and sign)	n (for compound	l prescrip	otions ONLY)			_						
• List VALID 11 digit NDC number (highest to lo cost) in the box at right. Include EACH ingrediused in the compound prescription.		Rx#		Date Filled		Days Supply						
 For each NDC number, indicate the metric quexpressed in the number of tablets, grams, moreams, ointments, injectables, etc. 		VALID 11 digit NDC#			Quantity*	Ingred Cost [†]	gredient est [†]					
• Indicate the TOTAL amount paid by the patien	nt.											
• Receipt(s) must be provided with this claim for	rm.											
* Individual quantities must equal the total qua † Individual ingredient costs plus compounding must be equal to the total ingredient costs.	•											
Y		Compounding Fee										
Signature of Pharmacist				Total								

Section C - Coordination of Benefits

Sometimes you can have both Medicare and another insurance plan. They work together to pay claims for the same person. That process is called coordination of benefits. Insurance companies coordinate benefits to:

-Avoid duplicate payments by making sure the two plans don't pay more than the total amount of the claim.

You must submit claims within one year of date of purchase or as required by your plan.

When submitting an Explanation of Benefits (EOB) from another health plan or Medicare: If you have not already done so, submit the claim to the primary plan or Medicare. Once you receive the EOB, complete this form, submit the pharmacy receipts, and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the primary plan or Medicare.

When submitting a copay receipt: If your primary plan requires you to pay a copayment or coinsurance to the pharmacy, then no EOB is needed. Just complete this form and submit the pharmacy receipts showing the amount you paid at the pharmacy. These receipts will serve as the EOB.



The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

請注意:如果您說中文 (Chinese),公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通,我们提供一些免费服务,例如用其他语言书写的信件或大字体。您也可以要求与口译员对话。欲寻求帮助,请拨打您的 ID 卡上列出的免费电话号码。