



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.**

1 Member Information

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)		

2 Physician and Pharmacy Information

Prescribing Physician Name			Pharmacy Name		
Prescribing Physician Phone Number with Area Code			Pharmacy Phone Number with Area Code		

3 Reason for Request

Filled not using a prescription ID card <input type="checkbox"/> YES <input type="checkbox"/> NO Covered under another health plan <input type="checkbox"/> YES <input type="checkbox"/> NO • If yes, is this other plan Primary <input type="checkbox"/> YES <input type="checkbox"/> NO • If primary, include the explanation of benefits (EOB), primary health plan name: _____ • See section C on back of form – Coordination of benefits My pharmacy billed the wrong plan <input type="checkbox"/> YES <input type="checkbox"/> NO A compound prescription (Pharmacist must fill out Section B on back of form) <input type="checkbox"/> YES <input type="checkbox"/> NO Retroactively enrolled with the plan <input type="checkbox"/> YES <input type="checkbox"/> NO Filled while waiting for drug approval <input type="checkbox"/> YES <input type="checkbox"/> NO	Filled at a non-network pharmacy: • Illness while traveling outside of service area <input type="checkbox"/> YES <input type="checkbox"/> NO • Network pharmacy/mail order pharmacy within reasonable driving distance could not fill in a timely manner <input type="checkbox"/> YES <input type="checkbox"/> NO • While a patient at a health care facility (emergency dept., provider clinic, outpatient surgery) <input type="checkbox"/> YES <input type="checkbox"/> NO • Due to federal or state emergency/natural disaster <input type="checkbox"/> YES <input type="checkbox"/> NO
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Part D Vaccine(s)

Vaccine received at: <input type="checkbox"/> Pharmacy <input type="checkbox"/> Doctor's office	Vaccine administered at: <input type="checkbox"/> Pharmacy <input type="checkbox"/> Doctor's office
Claim applies to: <input type="checkbox"/> Administration cost <input type="checkbox"/> Vaccine cost	
<input type="checkbox"/> Other (please explain) _____	

4 Acknowledgement

I certify that the patient for whom this claim is made is covered in this prescription drug program and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

X _____ **Member or Authorized Representative Signature** _____ **Date**

NOTE: If form is completed and signed by an Authorized Representative rather than the member, an Authorization of Representation (AOR) must accompany the request or Power of Attorney (POA) must be on file with the plan.



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。