



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

3 Reason for Request

Select appropriate options for your request:

- I did not use my prescription drug ID card.
- I used a non-participating pharmacy for one of the following reasons:
 - I traveled outside my plan's service area and needed my medication but could not access a network pharmacy.
 - I could not get my medication in a timely manner from either a network pharmacy located within a reasonable driving distance or a network mail service pharmacy.
 - A non-network pharmacy located within a care institution (emergency department, provider based clinic, outpatient surgery or other outpatient facility) dispensed my medication while I was a patient.
 - I was evacuated or displaced from my residence due to a state or federally declared disaster or health emergency.
- I filled a compound prescription (*your pharmacist must complete Section B on the back of this form*).
- My primary coverage is with another insurance carrier (*coordination of benefits claim, see Section C on back for details*).
 - I am submitting an Explanation of Benefits (EOB) from another health plan or Medicare.
Primary Health Plan Name: _____
 - I am submitting a copay receipt.
- I was waiting for a drug approval.
- I was retroactively enrolled with the plan.
- My pharmacy billed the wrong plan.
- Vaccine and/or vaccine administration
 - Vaccine prescription filled at: Pharmacy Physician's office
 - Vaccine administered by: Pharmacy Physician's office
 - Applicable to cost of claim (select all that apply): Administration cost Vaccine cost
- 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.

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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。