Medicare Part D: Prescription Claim Form





Important!

- Your claim will be processed within 14 days of receipt. Please allow additional time for all associated mailings.
- - Keep a copy of all documents submitted for your records.
 - Do not staple or tape receipts or attachments to this form.

Please check if applicable:

O This prescription was covered by a manufacturer patient assistance program.

Patient Information STEP 1

This section must be fully completed to ensure proper reimbursement of your claim.

Patient Information Identification Number (refer to your prescription card) **Group No./Group Name** Name (Last Name) (First Name) (MI)Address Address 2 City State Zip Date of Birth Phone Number Male Female

Other Insurance Information

PLEASE CHOOSE FROM BELOW:	TYPE OF REQUEST:		
Is the medicine covered under any other insurance?	Is this a request for a drug tier change? □YES □NO		
□ YES □ NO If yes, is other coverage: □ PRIMARY □ SECONDARY	Were any of these medicines received from a compounding facility?		
If other coverage is Primary, include the explanation of benefits (EOB) with this form.	Were any of these medicines received from a hospital?		
Name of Insurance Company:	Were any of these medicines received from a long term care facility? YES NO Were any of these medicines received while on vacation? YES NO		
ID#:			

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

Signature of Plan Participant

Date

Please note: If completing this form on behalf of a Medicare Part D member, please submit a completed CMS 1696 form (Appointment of Representative form). Per CMS regulations, a purported representative may submit a completed a CMS 1696 form or a form that includes the same information as a 1696 form.

STEP 2 Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will <u>only</u> be accepted for	
diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:	

 Patient Name 	 Prescription Number 	 Drug's 11 Digit NDC Number 	 Date of Fill 	 Quantity of Drug 	 Total Paid
• Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)					

Pharmacy name and address or pharmacy NABP number:

Prescribing physician's name:

Prescribing physician's address: _____

Prescribing physician's phone number:

Additional comments:

Number of prescriptions you are submitting for reimbursement:

n 1	Prescription (Rx) Number	Drug Name	
Prescription	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)
Pre	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply
n 2	Prescription (Rx) Number	Drug Name	
Prescription	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)
	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply
n 3	Prescription (Rx) Number	Drug Name	
Prescription	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)
Pre	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply

Please utilize Additional Prescription Information page if necessary (more than 3 prescriptions).

STEP 3	Mail completed forms with receipts	to:	Fax completed forms with receipts to:	
	Claims Department Part D Services P.O. Box 52077 Phoenix, AZ 85072-2077	OR	Fax: 1-401-652-1911	
 IMPORTANT REMINDER—To avoid having to submit a paper claim form: Always have your prescription card available at time of purchase. Always use pharmacies within your network. If problems are encountered at the pharmacy, call the number on the back of your card. 				

Additional Prescription Information

n 4	Prescription (Rx) Number	Drug Name		
Prescription 4	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)	
Pre	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply	
Prescription 5	Prescription (Rx) Number	Drug Name		
	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)	
	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply	
n 6	Prescription (Rx) Number	Drug Name		
Prescription 6	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)	
	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply	
n 7	Prescription (Rx) Number	Drug Name		
Prescription 7	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)	
	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply	
on 8	Prescription (Rx) Number	Drug Name		
Prescription 8	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)	
Pre	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply	
Prescription 9	Prescription (Rx) Number	Drug Name		
	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)	
Pre	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply	