CareSource Health Care with Heart | Ohio Department of Medicaid Next Generation MyCare | EVERNORTH HEALTH SERVICES

Medicare Part D Prescription Drug Claim Form

Section 1 – Cardholder Information

Cardholder Number _____ Group Number _____

Cardholder Name (*Last, First*) _____ Date of Birth _____

Street Address _____ Phone _____

City _____ State _____ ZIP _____

Section 2 – Other Prescription Drug Coverage *(Check all that apply)*

☐ This claim was submitted to or partially paid for by another insurance plan.
(Be sure to include the Explanation of Benefits from the other insurance company.)

☐ This prescription was purchased using a discount card.
(Ex: GoodRx, InsideRx, etc.)

☐ Another Insurance Plan paid for this Claim in error and that Plan sent you a Collection Letter.
(Be sure to include the collection letter with your claim)

Section 3 – Provider of the Prescription

Pharmacy Name _____ Pharmacy NPI _____

Street Address _____ Phone _____

City _____ State _____ ZIP _____

☐ My physician provided the vaccine or drug. See Section 5 for physician information.

Section 4 – Reason for Purchasing Out of the Plan's Network

☐ I traveled outside my plan's service area and ran out of (or lost) my medication; or I became ill and could not access a network pharmacy.

☐ I was unable to obtain my medication in a timely manner within my service area (there was no network pharmacy within a reasonable driving distance that provides 24/7 service).

☐ My medication is not stocked regularly at an accessible network or mail-order pharmacy.

☐ While I was a patient in an emergency department, provider-based clinic, outpatient surgery or other outpatient facility, my medication was dispensed from an out-of-network pharmacy located in one of these institutions, and I could not get my medication filled at a network pharmacy.

☐ I received a vaccine at my doctor's office or pharmacy.

☐ I was evacuated or displaced from my residence due to a State or Federally declared disaster or health emergency.

Section 5 – Physician Information

Physician Name _____ Physician NPI _____

Physician Address _____ Phone _____

City _____ State _____ Zip _____

Section 6 – Prescription Detail *(To be completed and signed by physician or pharmacist if receipt is not attached)*

Drug Name _____ NDC _____ Total Paid $ _____

Date of Service _____ Rx # _____ Qty _____ Days Supply _____

Special Situations:

- ☐ Vaccine Claim: Drug Cost $ _____ Admin Fee $ _____ Total Paid $ _____
- ☐ Compound Prescription *(Include a copy of the detailed receipt from the pharmacy showing all ingredients with costs)*
- ☐ Medication was Purchased Outside of the U.S.A. *(This includes prescriptions on a cruise ship)*
- ☐ Medication was Administered during an Emergency Dept. Observation Stay or at an Outpatient Facility. *(See Section 4, Option "D". Please provide a list of drugs that includes the National Drug Code (NDC) and cost for each drug)*

Pharmacist/Physician Signature _____ NPI _____ Date _____

Section 7 – Cardholder Signature

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be made according to the limits of your prescription benefit plan and will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid. Claims that are hard to read or incomplete may be returned or payment denied. If someone is submitting the claim on the beneficiary's behalf, an Authorization of Representation form (Form CMS-1696) or a legal document demonstrating representation must be attached. See the instructions for more information.

Warning: 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 denial of benefits, fines or imprisonment.

Signature _____ Date _____ ☐ Signed by Representative

Section 8 – How to Submit the Claim *(All reimbursement requests must be submitted in writing)*

Via Mail:
Express Scripts
ATTN: Medicare Part D
P.O. Box 52023
Phoenix AZ 85082

Via Fax – You may also fax your claim form to: 1-608-741-5483. Please use one claim form per fax. Do not combine claims for different members in the same fax submission. Reimbursement requests may be submitted up to 36 months from the date of service.

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Instructions for Medicare Part D Prescription Drug Claim Form

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM.

Purpose

The Prescription Drug Claim Form is offered as a tool to assist in getting your request for reimbursement paid as soon as possible. Use of the form is not required, but it is strongly encouraged. The information requested is needed to process your claim.

Please print clearly. Please note that missing, incomplete, hard-to-read, or ambiguous documentation can delay the successful processing of your claim.

This form can be used to request reimbursement for any of the following Medicare Part D prescription drug situations:

Routine Prescriptions – You purchased a prescription from a pharmacy without using your Medicare Part D benefit card.

Hospital Observation – You were admitted to a hospital or outpatient facility for up to three days for an observation and you were not allowed to bring the drugs you take on a daily basis from home. The are called self administered drugs. Only self administered drugs are covered by Medicare Part D.

Vaccines – You were administered a Medicare Part D approved vaccine. Be sure to check option "E" in **Section 4** and follow these instructions for submitting vaccine claims:

- If the vaccine was supplied and administered by your doctor, include the physician's invoice, check the box in **Section 3** but leave the rest blank, complete **Section 6** including checking the box for a Vaccine claim and complete the rest of the form.
- If the vaccine was purchased from and administered by a pharmacy, include the prescription receipt, skip **Section 5,** complete **Section 6** including checking the box for a Vaccine claim and complete the rest of the form.
- If the vaccine was purchased from a pharmacy but administered by your doctor, include the prescription receipt from the pharmacy and the physician invoice from the doctor, complete **Section 6** including checking the box for a Vaccine claim and complete the rest of the form.
- If the vaccine was free but there was an administration fee, this fee cannot be reimbursed. An administration fee can only be covered by Medicare Part D if you paid for the vaccine.

Compound Prescriptions – A compound prescription is composed of multiple ingredients combined to form a treatment that isn't readily available. If you are not sure whether you received a compound prescription, ask your pharmacist.

Please note: not all plans cover compound prescriptions. Special instructions for compound prescriptions include:

- Request a receipt from the pharmacy that lists all of the ingredients. The list should include the National Drug Code (NDC), metric quantity and cost for each ingredient. Submit the phar- macy receipt with your claim.
- Check the box for Compound Claim in **Section 6** and complete the rest of the form.

Receipts

A receipt is **required** to be properly reimbursed for a Medicare Part D prescription drug claim. Please note: a cash register receipt is not sufficient. Please tape your receipt(s) to an 8.5x11 sheet of paper or submit a clear photo copy. Keep a copy for your records. Acceptable receipts include:

Prescription Receipt – This receipt is provided by the pharmacy. It shows the pharmacy information, date of service or fill date, physician, Rx number, drug name, eleven-digit NDC, quantity, days supply and amount you paid. This is usually the receipt attached to the outside of the prescription envelope.

(continued on next page)

Physician Invoice – This will come from your doctor if you have been administered a vaccine. It should provide the doctor's information (ex. name, address, and phone number), date of service, drug name, drug NDC, and amount you paid, including any administration fee.

Hospital Invoice – This will be an itemized statement from the hospital resulting from an observation stay See **Section 4**, Option D for a definition. Please identify the drugs on the statement for which you are submitting a claim. Only identified drugs will be considered for reimbursement.

Section 1: Cardholder Information

Please fill in this section completely. This is critical information so that the claim is processed under the benefit to which you are entitled. The Cardholder Identification/ID number and Group number can be found on your Medicare Part D benefit card.

Section 2: Other Prescription Drug Coverage

Check any of the boxes in this Section that apply to your claim.

Section 3: Pharmacy Information

Please provide as much information as possible about the pharmacy where the drug or vaccine was purchased, including the National Provider Identifier (NPI) number. The NPI should be on the prescription drug receipt. Otherwise, the pharmacy can provide it.

Section 4: Out-of-Network Purchase

Please check the reason that best applies to your situation.

Section 5: Physician Information

All of the information requested in this section is critical to successfully processing your claim per Medicare guidelines. Your claim may be denied if the physician information is not provided. You may have to contact the physician's office for their address, phone number, and National Provider Identifier (NPI) number.

Section 6: Prescription Detail

Complete this section with information from your pharmacy prescription receipt. As an alternative to a receipt, you can have your doctor or pharmacist complete and sign this section.

Special Situations – Check any that may apply to your claim and provide the information or documentation that is requested.

Section 7: Cardholder Signature

Please sign the claim form. If someone is submitting the claim on the patient's behalf, please check the Signed by Representative box and provide either an Authorization of Representation form (Form CMS-1696) or a legal instrument defining the Representative. Form CMS-1696 can be downloaded at www.cms.gov or obtained by calling the Customer Service phone number on your card.

Section 8: Submit the Claim

The claim **must** be submitted in writing. It may be submitted via mail to or via fax as show in this Section on the Medicare Part D Prescription Drug Claim Form.

Please note: Reimbursement requests may be submitted up to 36 months from the Date of Service.