Prescription Drug Claim Form

Please use this form when you paid for a Medicare Part D covered prescription drug and are asking us to pay you back. Check your Evidence of Coverage (EOC) for more details on completing this form.

☐ If you wish to have another person complete this form on your behalf, please check this box and return a signed ***Appointment of Representative Form (AOR)*** - Form CMS-1696 along with this claim form. The **AOR** form is located on your plan's website or the Centers for Medicare & Medicaid Services (CMS) website.

MEMBER INFORMATION

First Name:	Last Name:	Member ID Number:
Birth Date:	Address:	City
Phone Number:	State:	Zip Code:

INSTRUCTIONS

Complete this form for each claim and include the prescription label information and a proof of payment receipt. The claim MUST include the following information in your request. You can locate the information on your prescription label, or you may ask your pharmacy to help.

1. Pharmacy NPI (National Provider ID)
2. Date of Fill
3. Physician Name
4. Physician NPI (National Provider ID)
5. Prescription (RX) Number
6. Amount Paid
7. Quantity Dispensed
8. Day Supply
9. Drug Name
10. National Drug Code

ABC Pharmacy #1234
NPI: 1234567890 (1)
123 Any Road
Tampa, FL 12345-6789

(813)555-1234
Date of Fill: 1/1/2008 (2)
Physician Name: Smith (3)
NPI: 1234567890 (4)

John Doe
RX#: 1234567 (5)

Take one (1) capsule by mouth three (3) times daily.
Copay: $10.00 (6)

Amoxicillin 500mg capsules (Teva) (9)
12345-6789-01 (10)

Quantity Dispensed: 30 (7)
Day Supply: 10 (8)
Refills Remaining: 1
Original Date: 1/1/2008

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REASON FOR REQUEST

☐ Received drug during hospital stay
☐ No Member ID card available
☐ Out-of-Network pharmacy used
☐ Emergency, please describe below
☐ Copayment error
☐ Pharmacy unable to process claim on-line
☐ Vaccine
☐ Other, please describe below

Coordination of Benefits – Other Insurance

- Are these drugs being taken for an on-the-job injury? ☐ Yes ☐ No
- Are these drugs covered under any other insurance? ☐ Yes ☐ No
- If yes, is other coverage: ☐ Primary ☐ Secondary

If other coverage is Primary, please attach a copy of your Explanation of Benefits (EOB).

Name of other insurance company:	Other insurance policy number:
Name of other insurance policyholder:	Name of policyholder's employer:

MAIL COMPLETED FORM TO:

Medicare Part D Pharmacy Claims
Attn: Member Reimbursement Department
PO Box 31577
Tampa, FL 33631-3577

Please note: Forms that are missing information, are not legible, or if the bill is not yet paid, may result in a delay or denial. A repayment of the amount you paid is not guaranteed.

I certify that the above information is correct.

X

Member or Appointed Representative Signature

Date

Requested Prescription Drug Information

You may use the following space to list all covered prescription drugs you paid for and would like us to pay you back. Only the drugs listed in this section will be considered. Please clearly mark the information into each box.

Drug Name:	Physician Name:	Physician NPI:	Pharmacy NPI:	RX Number:
National Drug Code:	Date of Fill:	Quantity:	Day Supply:	Amount Paid:

Drug Name:	Physician Name:	Physician NPI:	Pharmacy NPI:	RX Number:
National Drug Code:	Date of Fill:	Quantity:	Day Supply:	Amount Paid:

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