



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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