



## Medicare Advantage Prescription Drug Plan Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription label receipt(s) within 90 days.**

Please make and retain a copy of the receipts for your records.

**Cash register and credit card receipts alone are not acceptable as proof of purchase.**

Claims are reviewed, subject to limitations, exclusions and other provisions of the Plan Benefit.

**Reimbursement is not guaranteed.**

### Patient Information (Complete one form per member)

Health Plan/Insurance Name & State <i>(please print)</i>	Group Name	HIC Number
Name <i>(Last Name, First Name, Middle Initial)</i>	Birth Date	Prescriber I.D. Number
Mailing Address <i>(Number, Street, City, State &amp; Zip Code)</i>		
Prescribing Physician's Name	Physician's DEA or NPI number. <i>(Obtain from physician)</i>	Physician's Telephone Number

### Reason For Request

Write the reason here:

### Coordination of Benefits

*(If your primary insurance has already paid for the attached prescription and you are seeking additional reimbursement, please complete this section.)*

**An Explanation of Payment from the primary insurance must include the dollar amount paid by the primary insurance.**

Primary Health Plan/ Insurance Company Name \_\_\_\_\_

Primary Member/Subscriber's Name *(Last Name, First Name, Middle Initial)* \_\_\_\_\_

### Vaccine and Vaccine Administration

<input type="checkbox"/> Filled at pharmacy, & administered at physician's office <input type="checkbox"/> Filled and administered at pharmacy <input type="checkbox"/> Filled and administered at physician's office	<p style="text-align: center;"><b>Check below all that apply to the cost of the claim</b></p> <input type="checkbox"/> Administration Cost <input type="checkbox"/> Vaccine Cost
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### Compound Prescriptions Only (Pharmacist must complete and sign)

- List the VALID 11 digit NDC number (highest to lowest cost) in the box at the right for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments,
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be provided with claim form

Rx#	Date Filled	Days' Supply	Valid 11 digit NDC#	Quantity
<b>Total Quantity</b>				
<b>Total Charge</b>				

### Signature of Pharmacist X \_\_\_\_\_

I certify that the patient for whom this claim is made is a covered person 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.

**Member's/Subscriber's Signature** X \_\_\_\_\_ **Date** \_\_\_\_\_

### Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Pharmacy Name</li> <li>• Drug name, strength, and quantity</li> <li>• Prescribing physician's name</li> </ul> | <ul style="list-style-type: none"> <li>• Prescription number and date filled</li> <li>• Member paid expense</li> </ul> |
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Please mail label receipt(s) and this completed form to:

**Prescription Solutions**  
P.O. Box 29045  
Hot Springs, AR 71903

Reimbursement and correspondence will be issued to the primary member/subscriber.