

MEDICARE PRESCRIPTION DRUG CLAIM FORM

INSTRUCTIONS

- To process your claim as quickly as possible, please provide all information requested.
- Ask your pharmacist for the drug information on this form. Prescription receipts or a pharmacy-generated drug summary must be attached. Cash register receipts are not acceptable.
- Find your identification number on your member ID card.
- Use a separate claim form for each patient and pharmacy.
- If you are submitting more than two prescription claims, please use a new claim form.
- Fill out all fields for each submitted prescription.
- NPI – National Provider Identifier – a 10-digit identification number assigned to health care providers.

Example of how to complete the Prescription Drug Claim Form

1 Rx Number	000006011481
Date Filled	10 / 01 / 2010
Quantity	60
Day Supply	30
Name of Medication	"Drug Name"
NDC Number	00186502228
NPI Number	9215241163
Prescription Cost	\$ 146 . 04
Balance Due	\$.

- If additional claim forms are needed, call Member Services at the number listed on the back of your member ID card.
- Mail completed claim form along with prescription receipts to:

PrimeWest Health
 P.O. Box 14429
 Lexington, KY 40512

If you need information or help, call us at:

Toll Free: 1-800-366-2906
 TTY/TDD: 1-800-627-3529 or 711
 Daily, 8 a.m. to 8 p.m., Central Time.

Other resources to help you:

1-800-MEDICARE (1-800-633-4227)
 TTY/TDD: 1-877-486-2048, available 24 hours/day,
 7 days/week except federal holidays.

H2416_PW_2011_1057R_12_11/H2926_PW_2011_3057R_12_11
 DHS_Approved_12/28/2011/CMS_Approved_12/30/2011

CLAIM SUBMISSION

- DO NOT include charges for durable medical equipment. DO NOT submit canceled checks. DO NOT submit cash register slips. These are not acceptable as substitutes for original receipts. DO NOT submit statements with balance amounts only.

HOW TO COMPLETE THIS FORM

- Your member ID number can be found on your member ID card.
- Sign and date in the space provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send in your claim(s). No documents will be returned.

COMPOUND INFORMATION

- If a compound prescription, enter the NDC number for the most expensive ingredient.

COMPOUND PRESCRIPTIONS			
For pharmacy use only			
NDC number	Drug ingredient	Quantity	Charge

I certify the following:

The information on this form is correct. The patient indicated here is eligible for benefits. The patient has received these medications. I approve the release of information on this form to Prime Therapeutics. I agree that any benefits payable here for prescription drugs are not assignable. I agree that any further assignment shall be void. I also state that there has been no assignment of these benefits.

X

Patient/Member Signature

Health Care Fraud Notice - Fraud Hotline at 1-800-706-4071. TTY/TDD 1-800-693-3816. Monday through Friday, 8 a.m. to 5 p.m. CT. Health care fraud affects us all and causes an increase in health care costs. If you know or suspect any type of health care insurance fraud, please call us at the fraud hotline. All calls are confidential. You may report your concerns anonymously via our toll free hotline.

PrimeWest Senior Health Complete (HMO SNP) and Prime Health Complete (HMO SNP) are Coordinated Care Plans with Medicare Advantage contracts and contracts with the Minnesota Medicaid program.

MEDICARE PRESCRIPTION DRUG CLAIM FORM

MEMBER INFORMATION

Date of Birth / /

Identification (ID) Number

Member Name (First, Last) _____

Street Address _____

City _____ State _____ ZIP _____

OTHER HEALTH INSURANCE INFORMATION

Is this medication for an on-the-job injury? Yes No

Is this medication related to an auto accident? Yes No

Do you have other insurance that includes prescription drug coverage? Yes No

If yes, please submit claim form with **both** items below:

1. Copy of both sides of other health insurance ID card
2. Explanation of Benefits (EOB) from other health insurance. Please include amount paid and/or rejection of these prescriptions.

Was an out-of-network pharmacy used? . . . Yes No

If yes, provide reason below:

- I was traveling within the United States, but outside of the Plan's service area. I became ill or lost or ran out of my prescription drugs.
- I was unable to get a covered drug in a timely manner. There was not a network pharmacy nearby that provided 24/7 service.
- I was trying to fill a covered drug not regularly stocked at a network retail or mail order pharmacy. (This might include orphan drugs or specialty pharmaceuticals.)
- I was a patient in one of these:
 - Emergency department
 - Provider-based clinic
 - Outpatient surgery
 - Other outpatient setting

PHARMACY INFORMATION

Pharmacy Name _____

Pharmacy Address _____

City _____ State _____ ZIP _____

PRESCRIPTION CLAIM INFORMATION

Original pharmacy receipts are required. Do not staple.

Is this prescription claim for a compound medication?

Yes No

Note: If yes, make sure your pharmacist lists the NDC number for the active ingredient.

Receipts must include:

- ✓ Pharmacy name
- ✓ Strength
- ✓ Drug name
- ✓ Date purchased
- ✓ Quantity
- ✓ Drug charge
- ✓ NDC number
- ✓ Days supply
- ✓ NPI number
- ✓ Prescription number
- ✓ OHI Paid Amount (if COB)

All fields below must be completed.

Call your pharmacist if you need assistance.

1	Rx Number	<input type="text"/>
	Date Filled	<input type="text"/> / <input type="text"/> / <input type="text"/>
	Quantity	_____ Day Supply _____
	Name of Medication	_____
	NDC Number	<input type="text"/>
	NPI Number	<input type="text"/>
	Prescription Cost	\$ <input type="text"/> . <input type="text"/>
	Balance Due	\$ <input type="text"/> . <input type="text"/>

2	Rx Number	<input type="text"/>
	Date Filled	<input type="text"/> / <input type="text"/> / <input type="text"/>
	Quantity	_____ Day Supply _____
	Name of Medication	_____
	NDC Number	<input type="text"/>
	NPI Number	<input type="text"/>
	Prescription Cost	\$ <input type="text"/> . <input type="text"/>
	Balance Due	\$ <input type="text"/> . <input type="text"/>