CLAIM FORM INSTRUCTIONS

Please read carefully before filling out this form. **Missing information may delay your request for payment. Submitting a claim does not guarantee that you will be paid back.**

Part 1: Member Information (to be completed by the member)

1. Fill in Part 1. Your member ID number is on your member ID card.
2. Send us your claims within 90 days of paying for a drug. If have questions, call the Member Services number on the back of your member ID card.
3. Send a separate claim form for each member. Also, send a separate claim for each pharmacy where you get prescriptions.
4. **IMPORTANT NOTE: We will send payments and all other correspondence to the member's address unless you give us an Alternate Address in Part 1.**

Part 2: Receipt Information (can be completed by the pharmacy)

1. Include original prescription receipts/labels that have the required information (see example below). Or, ask your pharmacist to complete Part 2 and Part 3 of the form. If you do not have a receipt for your prescription(s), the pharmacist will need to sign in Part 3.
2. Tape receipts to a separate page and submit it with the claim form. Note: Do not staple receipts or other documentation to the claim form.
3. For more than one claim, please use the multiple prescription form.

Part 3: Pharmacy Information (to be completed by the pharmacy)

1. If required information is not available on the receipt, ask your pharmacist to complete Part 2 and Part 3.
2. Remember to keep a copy of the completed claim form and receipt(s) for your records.
3. Send the completed form and receipt(s) to:

MedImpact Healthcare Systems, Inc.
P.O. Box 509108
San Diego, CA 92150-9108

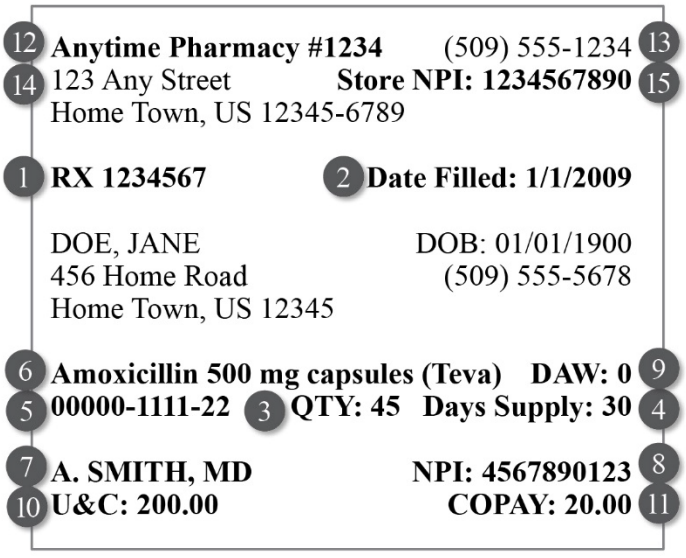
Fax: 1-858-549-1569
Email: Claims@Medimpact.com

Prescription/Pharmacy Information

Below is a numbered list of information we need you to provide. On the right is an example of a pharmacy receipt that contains the information. Use this example to help you find the required information on your receipt (items are numbered). Your pharmacy may have a different label format.

1. RX Number*
2. Date Filled*
3. Quantity*
4. Days Supply*
5. National Drug Code (NDC)*
6. Medication Name and Strength*
7. Physician Name
8. Physician National Provider ID (NPI)*
9. DAW
10. Usual and Customary Price (U&C)/RX Price*
11. Copay*
12. Pharmacy Name*
13. Pharmacy Phone Number
14. Pharmacy Address
15. Pharmacy National Provider ID (NPI)*

***Required information. Without it, your payment may be delayed.**



PART 1 **Information required to process a claim. If this information is not included, it may delay your request for payment.*

Member ID Number*	Group Number	
Name of Health Plan/Insurance	Member Name*	DOB: (mm/dd/yyyy)* / /
Alternate Address: (Street, City, State, Zip code) ***If no alternate address is specified, correspondence and/or payment will be sent to the member address we have on file for you.**		
Member Signature*	Telephone Number ( )	Date

Tell us the reason for manually filing these claims (select one):

☐ Coordination of Benefits – Claims must be submitted with pharmacy receipt(s) identifying copays paid **and** an ***Explanation of Benefits*** from the primary carrier (or prescription history from the pharmacy showing primary insurance payment)
☐ Discount card was used
☐ Health plan/insurance information or insurance card not available at the time of purchase
☐ Pharmacy not participating in network
☐ Pharmacy unable to process claim electronically
☐ Member was administered a Part D-covered vaccine in provider's office or clinic (cost for vaccine and administration fees must be listed separately)
☐ Emergency – If Emergency, describe emergency below

_____

PART 2

RX Number	Date Filled* / /	New ☐ Refill ☐	Quantity*	Days Supply*	National Drug Code (11 Digit)*
Medication Name and Strength*			Physician Name*:		Physician NPI*:
RX Price* $			Copay* $		Administration Cost $

Compound? ☐Yes ☐No (If yes, please identify NDC ingredients and quantity on the Compound Claim Form**)**

PART 3: Affix Pharmacy Label Here or Populate the Information:

Pharmacy Name*			Pharmacy Telephone Number	
Street Address			NPI*	
City	State	Zip	Pharmacist Signature	Date

Multiple Prescription Claim Form

RX Number	Date Filled* / /	New ☐ Refill ☐	Quantity*	Days Supply*	National Drug Code (11 Digit)*
Medication Name and Strength*			Physician Name*:		Physician NPI*:
RX Price* $			Copay* $		Administration Cost $

Compound? ☐Yes ☐No (If yes, please identify NDC ingredients and quantity on the Compound Claim Form)

RX Number	Date Filled* / /	New ☐ Refill ☐	Quantity*	Days Supply*	National Drug Code (11 Digit)*
Medication Name and Strength*			Physician Name*:		Physician NPI*:
RX Price* $			Copay* $		Administration Cost $

Compound? ☐Yes ☐No (If yes, please identify NDC ingredients and quantity on the Compound Claim Form)

RX Number	Date Filled* / /	New ☐ Refill ☐	Quantity*	Days Supply*	National Drug Code (11 Digit)*
Medication Name and Strength*			Physician Name*:		Physician NPI*:
RX Price* $			Copay* $		Administration Cost $

Compound? ☐Yes ☐No (If yes, please identify NDC ingredients and quantity on the Compound Claim Form)

RX Number	Date Filled* / /	New ☐ Refill ☐	Quantity*	Days Supply*	National Drug Code (11 Digit)*
Medication Name and Strength*			Physician Name*:		Physician NPI*:
RX Price* $			Copay* $		Administration Cost $

Compound? ☐Yes ☐No (If yes, please identify NDC ingredients and quantity on the Compound Claim Form)

RX Number	Date Filled* / /	New ☐ Refill ☐	Quantity*	Days Supply*	National Drug Code (11 Digit)*
Medication Name and Strength*			Physician Name*:		Physician NPI*:
RX Price* $			Copay* $		Administration Cost $

Compound? ☐Yes ☐No (If yes, please identify NDC ingredients and quantity on the Compound Claim Form)

COMPOUND PRESCRIPTIONS

The pharmacy or dispensing facility must complete the remaining portion of this form and give it to the member OR give the member a Universal Claim Form for a Compounded Medication.*

- Provide an 11-digit NDC number for each of the ingredient(s) in the medication.
- Indicate the drug ingredient(s) and quantity.
- Indicate the metric quantity dispensed in number of tablets, grams, or milliliters for liquids, creams, ointments, or injectables.
- Indicate the amount paid for the prescription by the patient.

Compound Prescriptions (for pharmacy use only)			
NDC#	**Drug/Ingredient**	**Quantity**	**Charge**
		Total Charge:	$

The original pharmacy prescription label or payment receipt should be submitted with this claim form or the Universal Claim Form for a compounded medication. Prescription labels and receipts will not be returned. You may wish to make copies for your records.

PrimeWest HEALTH™

IMPORTANT CLAIM NOTICE

AL, AK, AZ, CT, DE, GA, ID, IL, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OR, RI, SC, SD, VT, WI, WY Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties. **Additionally, DE, ID, MN, NM, OH Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or criminal penalties.

Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. The formulary and pharmacy network may change at any time. You will receive notice when necessary.

PrimeWest Senior Health Complete (HMO SNP) and Prime Health Complete (HMO SNP) are health plans that contract with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in PrimeWest Senior Health Complete (HMO SNP) and Prime Health Complete (HMO SNP) depend on contract renewal.

1-866-431-0801 (toll free); TTY **1-800-627-3529** or **711**

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ၊. ဖဲနမ့၊လိဉ်ဘဉ်တ၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ် လီတဲစိနီ၊ဂံ၊်လၢထးအံၤန့ဉ်တကွ၊.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. PrimeWest Health does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by PrimeWest Health. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
PrimeWest Health
3905 Dakota St
Alexandria, MN 56308
Toll Free: 1-866-431-0801
TTY: 1-800-627-3529 or 711
Fax: 1-320-762-8750
Email: compliance@primewest.org

Auxiliary Aids and Services: PrimeWest Health provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact PrimeWest Health at memberservices@primewest.org, or call Member Services at 1-866-431-0801 or TTY 1-800-627-3529 or 711. The call is free.**

Language Assistance Services: PrimeWest Health provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact PrimeWest Health at memberservices@primewest.org, or call Member Services at 1-866-431-0801 or TTY 1-800-627-3529 or 711. The call is free.**

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by PrimeWest Health. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)
You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)
In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll-free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)
You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

PrimeWest Health Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-800-366-2906**. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-800-366-2906**. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-800-366-2906**。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-800-366-2906**。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-800-366-2906**. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-800-366-2906**. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-800-366-2906** sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-800-366-2906**. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-800-366-2906** 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-800-366-2906**. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-366-2906**. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-800-366-2906** पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-800-366-2906**. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-800-366-2906**. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-366-2906**. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-800-366-2906**. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-800-366-2906** にお電話くださぃ。日本語を話す人 者 が支援ぃたします。これは無料のサー ビスです。