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

San Diego, CA 92150-9108

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.*

<table>
<thead>
<tr>
<th>Member ID Number*</th>
<th>Group Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Health Plan/Insurance</td>
<td>Member Name*</td>
</tr>
<tr>
<td>DOB: (mm/dd/yyyy)*</td>
<td>/ /</td>
</tr>
</tbody>
</table>

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.*

<table>
<thead>
<tr>
<th>Member Signature*</th>
<th>Telephone Number</th>
<th>Date</th>
</tr>
</thead>
</table>

**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**

<table>
<thead>
<tr>
<th>RX Number</th>
<th>Date Filled* / /</th>
<th>New ☐ Refill ☐</th>
<th>Quantity*</th>
<th>Days Supply*</th>
<th>National Drug Code (11 Digit)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Name and Strength*</td>
<td>Physician Name*:</td>
<td>Physician NPI*:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 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:**

<table>
<thead>
<tr>
<th>Pharmacy Name*</th>
<th>Pharmacy Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>NPI*</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Pharmacist Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>
### Multiple Prescription Claim Form

<table>
<thead>
<tr>
<th>RX Number</th>
<th>Date Filled* / /</th>
<th>New ☐ Refill ☐</th>
<th>Quantity*</th>
<th>Days Supply*</th>
<th>National Drug Code (11 Digit)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Name and Strength*</td>
<td>Physician Name*:</td>
<td>Physician NPI*:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RX Price* $</td>
<td>Copay* $</td>
<td>Administration Cost $</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>RX Number</th>
<th>Date Filled* / /</th>
<th>New ☐ Refill ☐</th>
<th>Quantity*</th>
<th>Days Supply*</th>
<th>National Drug Code (11 Digit)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Name and Strength*</td>
<td>Physician Name*:</td>
<td>Physician NPI*:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RX Price* $</td>
<td>Copay* $</td>
<td>Administration Cost $</td>
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</tr>
</tbody>
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**Compound? ☐ Yes ☐ No** (If yes, please identify NDC ingredients and quantity on the Compound Claim Form)

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<tr>
<th>RX Number</th>
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<th>Quantity*</th>
<th>Days Supply*</th>
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<td>Physician NPI*:</td>
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<tr>
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<td>Copay* $</td>
<td>Administration Cost $</td>
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**Compound? ☐ Yes ☐ No** (If yes, please identify NDC ingredients and quantity on the Compound Claim Form)

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<th>RX Number</th>
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<td>Administration Cost $</td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>NDC#</th>
<th>Drug/Ingredient</th>
<th>Quantity</th>
<th>Charge</th>
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<tbody>
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</table>

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

1-800-366-2906 (toll free); TTY 1-800-627-3529 or 711

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.

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

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kennname 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) qoralkan, 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

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 1-800-366-2906 (toll free) or TTY 1-800-627-3529 or 711.

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 1-800-366-2906 (toll free) or TTY 1-800-627-3529 or 711.

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 contact any of the following four 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:
Director
U.S. Department of Health and Human Services’ Office for Civil Rights
200 Independence Avenue SW
Room 515F
HHH Building
Washington, DC 20201
Customer Response Center: Toll-free: 800-368-1019
TDD 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 believe 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
- 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

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. After we get your complaint, 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 the outcome 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

PrimeWest Health Complaint Notice
You have the right to file a complaint with PrimeWest Health if you believe you have been discriminated against because of any of the following:

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

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:
  Rebecca Fuller
  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: rebecca.fuller@primewest.org

American Indian Health Statement
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.