

Instructions for Medicare Part D Prescription Drug Claim Form

PLEASE READ THE FOLLOWING INSTRUCTIONS AND CAREFULLY COMPLETE THE FORM.

Purpose

The Prescription Drug Claim Form is offered as a tool to assist in getting your claim paid as soon as possible. Please print clearly. Use of the form is not required. You may submit equivalent written documentation, but it must provide all of the requested information on this form. Please note that missing, incomplete or hard-to-read documentation can delay the successful processing of your claim.

When to Use This Form

This form can be used to request reimbursement for any of the following Medicare Part D prescription drug benefits:

- Routine Prescriptions – You purchased a prescription without using your member ID card.
- Hospital Observation– You were admitted to the hospital for up to three days for an observation and you were not allowed to bring your daily drugs from home. During the observation, the only drugs covered by Medicare Part D are those that are administered because you take them on a regular basis (ex. daily) at home.
- Medicare Part D Vaccines – You purchased or had administered a Part D approved vaccine. Always check line **E.** in **Section 4** and follow these instructions for submitting vaccine claims:
 - If the vaccine was supplied and administered by your doctor or clinic, include the physician invoice, skip **Section 3**, skip **Section 6** and complete the rest of the form.
 - If the vaccine was purchased from and administered by a pharmacy, include the prescription receipt, skip **Section 5**, skip **Section 6** and complete the rest of the form.
 - If the vaccine was purchased from a pharmacy but administered by your doctor, include the prescription receipt from the pharmacy and the physician invoice from the doctor, skip **Section 6** and complete the rest of the form.

- If the vaccine was free, but there was an administration fee, include the receipt showing the cost of the vaccine as zero dollars and the cost of the administration fee. Complete **Section 3** if administered at a pharmacy or **Section 5** if administered by a physician or at a clinic. Skip **Section 6** and complete the rest of the form.
- Compound Prescriptions – You purchased a compound prescription without using your member ID card. Please note that not all plans cover compound prescriptions. Special instructions for compound prescriptions include:
 - A compound prescription is composed of multiple ingredients combined to form a treatment that isn't readily available.
 - If you are not sure whether you have a compound prescription, ask your pharmacist.
 - The easiest way to submit a claim for a compound prescription is to request a receipt from the pharmacy that lists all of the ingredients. The list should include the National Drug Code (NDC), metric quantity and cost for each ingredient. The pharmacy receipt should be submitted with your claim. To submit your claim, include the receipt, skip **Section 6** and complete the rest of the form.
 - An alternative to providing the receipt is to have the pharmacist complete and sign **Section 6**, including the **Compound Prescriptions Only** part. You would complete the rest of the form.
 - Check your plan benefit materials or call Customer Service at the number on your member ID card if you have questions regarding your compound prescription.

Specific steps to complete the form begin on side 2.

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Section 1: Cardholder Information

Please fill in this section completely. This is critical information so that the claim is processed under the benefit to which you are entitled. The Cardholder Identification/ID number and Group number can be found on your member ID card.

Section 2: Other Prescription Drug Coverage

- If Medicare Part D is your primary prescription drug coverage, then skip this section.
- However, if Medicare Part D is your secondary prescription drug coverage, please be sure to complete **Section 2** after a claim for this prescription has been submitted to your primary insurance and you have received an *Explanation of Benefits* document detailing the outcome of that claim. In order to properly process your claim, please include a copy of the *Explanation of Benefits* from the primary insurance provider with your claim.

Section 3: Pharmacy Information

Skip this section if your doctor supplied and administered a vaccine. For all other situations, please supply as much information as possible about the pharmacy where the drug was purchased, including the National Provider Identifier (NPI) number, to ensure that your claim can be processed. If you cannot find the NPI on the prescription drug receipt, the pharmacy can provide it.

Section 4: Out-of-Network Purchase

Please check the reason that best applies to your situation.

Section 5: Physician Information

All of the information requested in this section is critical to successfully processing your claim per Medicare guidelines. Your claim may be denied if the physician information is not provided. You may have to contact the physician's office for his/her address, phone number, and National Provider Identifier (NPI) number.

Receipts

To be properly reimbursed for a Medicare Part D prescription drug claim, a receipt is required. Please note that a cash register receipt is not sufficient. Please tape your receipt(s) to an 8.5x11 sheet of paper or submit a clear photo copy. Acceptable receipts include:

- Prescription Receipt – This receipt shows the pharmacy information, date of service, physician, Rx number, drug name, eleven-digit NDC, quantity, days supply and amount you paid. This is usually the receipt attached to the outside of the prescription envelope. As an alternative, you may request a prescription history report from your pharmacy for a given time period. As long as it shows all of the information noted in this paragraph and is signed by the pharmacist, this can serve as your pharmacy prescription receipt.
- Physician Invoice – This will normally come from your doctor if you have been administered a vaccine. It should provide the doctor's information (ex. name, address, and phone number), date of service, drug name, drug NDC, and amount you paid, including any administration fee.
- Hospital Invoice – This will be an itemized statement from the hospital resulting from an observation stay. It must include the hospital pharmacy NPI number, date of service, physician name, drug name, drug NDC, quantity, days supply and amount you paid. Please circle the drugs on the statement for which you are submitting a claim. Only circled drugs will be considered for reimbursement.

Section 6: Prescription Detail

Skip this section if you have a qualifying receipt as described above. If you cannot acquire any of the above receipts, have your doctor or pharmacist complete and sign this section.

Section 7: Cardholder Signature

Please sign the claim form. If someone is submitting the claim on the patient's behalf, an Authorization of Representation form (Form CMS-1696) or similar legal instrument must be included with the claim. Form CMS-1696 can be downloaded at www.cms.gov or obtained by calling the Customer Service number on your card.

Section 8: Submit the Claim

The claim may be submitted via mail or fax to the address or phone number on the Medicare Part D Prescription Drug Claim Form. Reimbursement requests may be submitted up to 36 months from the date of service.

UCare's MSHO (HMO D-SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UCare's MSHO depends on contract renewal.

Medicare Part D Prescription Drug Claim Form

Section 1 ▶ Cardholder Information

Cardholder Identification/ID # _____ Group # _____
Cardholder Name (*Last, First MI.*) _____
Street Address _____ Date of Birth _____
City _____ State _____ Zip _____

Section 2 ▶ Other Prescription Drug Coverage

Is the patient eligible for primary prescription drug coverage from another insurance company? Y N
If yes, did the patient submit the claim to this other insurance company? Y N
(*If yes, include the Explanation of Benefits from the other insurance company.*)
Did the other insurance company pay as the primary insurer? Y N

Section 3 ▶ Pharmacy Information

Pharmacy Name _____ Pharmacy NPI _____
Address _____ Phone _____
City _____ State _____ Zip _____

Section 4 ▶ Out-of-Network Purchase

- A. I traveled outside my plan's service area and ran out of (or lost) my medication; or I became ill and could not access a network pharmacy.
- B. I was unable to obtain my medication in a timely manner within my service area (there was no network pharmacy within a reasonable driving distance that provides 24/7 service).
- C. My medication is not stocked regularly at an accessible network or mail-order pharmacy.
- D. While I was a patient in an emergency department, provider-based clinic, outpatient surgery or other outpatient facility, my medication was dispensed from an out-of-network pharmacy located in one of these institutions, and I could not get my medication filled at a network pharmacy.
- E. I received a vaccine at my doctor's office or pharmacy.
- F. I was evacuated or displaced from my residence due to a State or Federally declared disaster or health emergency.

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Section 5 ➤ Physician Information

Physician Name _____ Physician NPI _____
Physician Address _____ Phone _____
City _____ State _____ Zip _____

Section 6 ➤ Prescription Detail

To be completed and signed by physician or pharmacist if receipt is not attached

Date of Service _____ Rx # _____ NDC _____
Drug Name _____ Qty _____ Days Supply _____ Drug Cost _____

Medicare Part D Vaccine Claim Only *(if covered)* Admin Fee _____ Total Paid by Cardholder _____

Compound Prescriptions Only *(if covered)*

11-digit NDC Number	Ingredient Name	Metric Quantity	Ingredient Cost
Total Paid by Cardholder			

Physician or Pharmacist Signature _____ Date _____

Section 7 ➤ Cardholder Signature

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be made according to the limits of your prescription benefit plan and will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid. Claims that are hard to read or incomplete may be returned or payment denied. If someone is submitting the claim on the patient's behalf, an Authorization of Representation form (Form CMS-1696) must be attached. See the instructions for more information.

Signature _____ Date _____

Section 8 ➤ Submit the Claim

Via Mail:
Express Scripts
ATTN: Medicare Part D
PO Box 14718
Lexington, KY 40512-4718

Via Fax – You may also fax your claim form to: 1.608.741.5483. Please use one claim form per fax. Do not combine claims for different members in the same fax submission. Reimbursement requests may be submitted up to 36 months from the date of service.

Toll Free 1-800-203-7225, TTY 1-800-688-2534

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

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ما أذلاحة: إرتد مسادة مجانية لتجرمة هه الوثيقة، ال على الرقم أعلاه

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း 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.

ဟ်သုဉ်ဟ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလိလၢတၢ်ကကျိးထံဝဲဒၣ်လံာ် တီလံာ်မိတခါအံၤန့ၣ်, ကိးဘဉ်လိတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

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

ໂປຣດຊາບ ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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 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.

CB5 (MCOs) (5-2020)

Civil Rights Notice

Discrimination is against the law. UCare 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. UCare 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** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Language Assistance Services. UCare 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** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. 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:

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

UCare Complaint Notice

You have the right to file a complaint with UCare if you believe you have been discriminated against in our health care programs 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 belief

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

UCare

Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Toll free: 1-800-203-7225
TTY: 1-800-688-2534
Fax: 612-884-2021
Email: cag@ucare.org