EXPRESS SCRIPTS®

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.

(over)

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.

EXPRESS SCRIPTS®

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.

(*over*)

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.

Notice of Nondiscrimination

UCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UCare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **612-676-3200 (voice)** or toll free at **1-800-203-7225 (voice)**, **612-676-6810 (TTY)**, or **1-800-688-2534 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**.

If you believe that UCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current UCare member, please call the number on the back of your membership card. Otherwise please call **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Email: cag@ucare.org
Fax: 612-884-2021

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 612-676-3200/1-800-203-7225（TTY：612-676-6810/1-800-688-2534）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-3200/1-800-203-7225 (телетайп: 612-676-6810/1-800-688-2534).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 612-676-3200/1-800-203-7225 (መስማት ለተሳናቸው: 612-676-6810/1-800-688-2534).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ် ကျိာ်အတၢ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ៉ខ្មែរ, រសវាជំនួយរ៉ផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរ៉ីអ្នក។ ចូរ ទូរស័ព្ទ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 612-676-3200/1-800-203-7225 (رقم هاتف الصم والبكم: 612-676-6810/1-800-688-2534).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).