Medicare Part D: Prescription Claim Form

Important!
- Your claim will be processed within 14 days of receipt. Please allow additional time for all associated mailings.
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.

IngenioRx

Please check if applicable:

◯ This prescription was covered by a manufacturer patient assistance program.

| STEP 1 | Patient Information | This section must be fully completed to ensure proper reimbursement of your claim. |

Patient Information

Identification Number (refer to your prescription card)

Group No./Group Name

Name *(Last Name)*

(First Name)

(MI)

Address

Address 2

City

State

Zip

Date of Birth ☐☐/☐☐/☐☐☐☐

Male ☐ / **Female** ☐

Phone Number

Other Insurance Information

PLEASE CHOOSE FROM BELOW:

Is the medicine covered under any other insurance?
☐ YES ☐ NO

If yes, is other coverage: ☐ PRIMARY ☐ SECONDARY

If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurance Company: _____

_____

ID#: _____

TYPE OF REQUEST:

Is this a request for a drug tier change? ☐ YES ☐ NO

Were any of these medicines received from a compounding facility?
☐ YES ☐ NO

Were any of these medicines received from a hospital?
☐ YES ☐ NO

Were any of these medicines received from a long term care facility?
☐ YES ☐ NO

Were any of these medicines received while on vacation?
☐ YES ☐ NO

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

X _____

Signature of Plan Participant **Date**

Please note: If completing this form on behalf of a Medicare Part D member, please submit a completed CMS 1696 form (Appointment of Representative form). Per CMS regulations, a purported representative may submit a completed a CMS 1696 form or a form that includes the same information as a 1696 form.

(Over)

STEP 2   Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will <u>only</u> be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

• Patient Name   • Prescription Number   • Drug's 11 Digit NDC Number   • Date of Fill   • Quantity of Drug   • Total Paid

• Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)

Pharmacy name and address or pharmacy NABP number: _____

Prescribing physician's name: _____

Prescribing physician's address: _____

Prescribing physician's phone number: _____

Additional comments: _____

Number of prescriptions you are submitting for reimbursement: _____

Prescription 1

Prescription (Rx) Number	Drug Name	
National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid ($ Amount)
Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply

Prescription 2

Prescription (Rx) Number	Drug Name	
National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid ($ Amount)
Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply

Prescription 3

Prescription (Rx) Number	Drug Name	
National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid ($ Amount)
Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply

Please utilize Additional Prescription Information page if necessary (more than 3 prescriptions).

STEP 3   Mail completed forms with receipts to: Fax completed forms with receipts to:

Claims Department
Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

OR

Fax: 1-401-652-1911

IMPORTANT REMINDER—To avoid having to submit a paper claim form:
- Always have your prescription card available at time of purchase.
- Use medication from your formulary list.
- Always use pharmacies within your network.
- If problems are encountered at the pharmacy, call the number on the back of your card.

Additional Prescription Information

Prescription 4

Prescription (Rx) Number

Drug Name

National Drug Code (NDC Number)

Date Filled (MM/DD/YY)

Total Paid ($ Amount)

Prescriber's National Provider Identifier Number

Quantity of Drug

Days Supply

Prescription 5

Prescription (Rx) Number

Drug Name

National Drug Code (NDC Number)

Date Filled (MM/DD/YY)

Total Paid ($ Amount)

Prescriber's National Provider Identifier Number

Quantity of Drug

Days Supply

Prescription 6

Prescription (Rx) Number

Drug Name

National Drug Code (NDC Number)

Date Filled (MM/DD/YY)

Total Paid ($ Amount)

Prescriber's National Provider Identifier Number

Quantity of Drug

Days Supply

Prescription 7

Prescription (Rx) Number

Drug Name

National Drug Code (NDC Number)

Date Filled (MM/DD/YY)

Total Paid ($ Amount)

Prescriber's National Provider Identifier Number

Quantity of Drug

Days Supply

Prescription 8

Prescription (Rx) Number

Drug Name

National Drug Code (NDC Number)

Date Filled (MM/DD/YY)

Total Paid ($ Amount)

Prescriber's National Provider Identifier Number

Quantity of Drug

Days Supply

Prescription 9

Prescription (Rx) Number

Drug Name

National Drug Code (NDC Number)

Date Filled (MM/DD/YY)

Total Paid ($ Amount)

Prescriber's National Provider Identifier Number

Quantity of Drug

Days Supply