



Medicare Part D Prescription Drugs Claim Form

Claim Form Instructions

Please read carefully before completing this form. **Claim forms that do not include the required information may delay or inhibit our ability to process your request for reimbursement. Completion and submission of this form does not guarantee reimbursement. Claims are subject to limitations, exclusions, and other provisions of your benefit plan.**

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

1. Complete all information under Part 1. The member/cardholder ID Number is located on your insurance card.
2. Submit claims within the filing period specified by your health plan. For questions about your filing period, please call the number on the back of your insurance card.
3. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.
4. **IMPORTANT NOTE: Payment and related correspondence will be sent to the primary subscriber unless you provide us with an Alternate Address in Part 1.**

Part 2: Receipt

1. Submit prescription receipts/labels that contain the requested information (shown below) or have your pharmacist complete Part 2 and Part 3. If you do not receive a receipt for your prescription(s), pharmacist signature is required.
2. Include all original pharmacy receipt(s). Tape receipts to a separate page to be submitted with the claim form.
Note: Please do not staple receipts or other documentation to the claim form.
3. For multiple claims, please use the multiple prescription form.

PRESCRIPTION/PHARMACY INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information. Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234		(509)555-1234
123 Any Street		Store NPI: 1234567890
Home Town, US 12345-6789		
RX 1234567	Date Filled: 1/1/2009	
DOE, JANE DOB: 01/01/1900		
456 Home Road		(509)555-5678
Home Town, US 12345		
Amoxicillin 500 mg capsules (Teva)	DAW: 0	
00000-1111-22	QTY: 45	Days Supply: 30
A. SMITH, MD		
NPI: 4567890123		
U&C: 200.00	COPAY: 20.00	

1. Date Filled*
2. RX Number
3. Quantity*
4. Day 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 National Provider ID (NPI)

** Denotes information required to process a claim. If this information is not included, it may delay or inhibit our ability to process your request for reimbursement.*

4. Remember to keep a copy of the completed claim form and receipt(s) for your records.
5. Send the completed form and receipt(s) to:

MedImpact Healthcare Systems, Inc.
PO Box 509108
San Diego, CA 92150-9108
Fax: 858-549-1569
E-mail: Claims@Medimpact.com



MedImpact.com

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Medicare Part D Prescription Drugs Claim

PART 1

*Indicates required information

Primary Subscriber/Cardholder ID Number*		Group Number	
Name of Health Plan/Insurance		Primary Subscriber Name*	DOB: (mm/dd/yyyy)* / /
Member Name: (First, Middle, Last)*	Date of Birth: (mm/dd/yyyy)* / /	Relationship to Primary Subscriber Self ☐ Spouse ☐ Dependent ☐	
Primary Subscriber Address: (Street, City, State, Zip code)			
Alternate Address: (Street, City, State, Zip code)			
*If no alternate address is specified, correspondence and/or payment will be forwarded to the primary subscriber address on file with your health plan/insurance.			
Member Telephone Number: ()			

Indicate 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
- ☐ Emergency – If Emergency, describe emergency below

Manual submission of claims does not guarantee reimbursement.

Describe Emergency: _____

PART 2

RX Number	Date Filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*	
Medication Name and Strength *			Physician Name & NPI Number Name: _____ NPI : _____		RX Price* \$	Co-Pay* \$

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

PART 3

Affix Pharmacy Label Here or Enter the Required Information:

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

I understand that anyone who knowingly or intentionally misrepresents, omits, or falsifies information requested by this form may be found guilty of a crime, and/or subjected to civil or criminal penalties. By signing below, I certify that I have read and understood this form, and that the information provided on this form is true and correct to the best of my knowledge.

Member or Authorized Representative Signature* _____

Date* _____

NOTE: If this form is completed and signed by an Authorized Representative, an Authorization of Representation (AOR) must accompany this form.



Medicare Part D Prescription Drug Claim Form

Multiple Prescription Claim Form

Must be attached to a Commercial or Part D Prescription Drug form

* Indicates Required Information

RX Number	Date Filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name: _____ NPI : _____		RX Price* \$	Co-Pay* \$
Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)						
RX Number	Date Filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name: _____ NPI : _____		RX Price* \$	Co-Pay* \$
Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)						
RX Number	Date Filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name: _____ NPI : _____		RX Price* \$	Co-Pay* \$
Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)						
RX Number	Date Filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name: _____ NPI : _____		RX Price* \$	Co-Pay* \$
Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)						
RX Number	Date Filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name: _____ NPI : _____		RX Price* \$	Co-Pay* \$
Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)						
RX Number	Date Filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name: _____ NPI : _____		RX Price* \$	Co-Pay* \$
Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)						
RX Number	Date Filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name: _____ NPI : _____		RX Price* \$	Co-Pay* \$
Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)						



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Medicare Part D Prescription Drugs Claim

Compound Claim Form

The pharmacy or dispensing facility must complete the remaining portion of this form and return it to the member/patient or provide the member/patient with 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*

Total Charge:			\$

Note: If the medication/drug was purchased in a foreign country, the currency must be converted into US dollars.

The original pharmacy prescription label or cash receipt should accompany 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.

Notice of Non-Discrimination

Doctors HealthCare Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate or exclude people on the basis of race, color, creed, religion, national origin, age, disability, political affiliations or beliefs, or sex (including pregnancy, sexual orientation, and gender identity).

Doctors HealthCare Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages
- If you need these services, contact Member Services/Civil Rights.

If you believe that Doctors HealthCare Plans has failed to provide these services or discriminated in another way, you can file a grievance with:

Doctors HealthCare Plans, Inc.

Attn: Member Services/Civil Rights
2020 Ponce De Leon Blvd, PH1
Coral Gables, FL 33134
Telephone: 833-342-7463 (TTY: 711)
Fax: 786-578-0293,
Email: civilrights@doctorshcp.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services/Civil Rights, is available to help you.

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, 800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE, AUXILIARY AIDS AND SERVICES

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids y services to provide information in accessible formats are also available free of charge. Call 833-342-7463 (TTY:711) or speak to your provider.

Spanish: ATENCIÓN: Si habla español, están disponibles servicios de asistencia lingüística gratuita para usted. También están disponibles sin carga adecuada apoyos y servicios para proporcionar información en formatos accesibles. Llame al 833-342-7463 (TTY:711) o hable con su proveedor.

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm akseib yo disponib gratis tou. Rele nan 833-342-7463 (TTY:711) oswa pale avèk founisè w la.

Arabic:

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم - (TTY: 711) (833-342-7463) أو تحدث إلى مقدم الخدمة".

Chinese Traditional: 注意: 如果您說[台語], 我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務, 以無障礙格式提供資訊。請致電 833-342-7463 (TTY:711) 或與您的提供者討論。」

Chinese Simplified: 注意: 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 833-342-7463 (文本电话: (TTY:711) 或咨询您的服务提供商。

French: ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 833-342-7463 (TTY: 711) ou parlez à votre fournisseur.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachhilfe-Dienste zur Verfügung. Angemessene Hilfsmittel und Dienste zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos verfügbar. Rufen Sie 833-342-7463 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter.

Gujarati: ધ્ યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. માહિતીને સુલભ સ્ વધુ માં આપવાની યોગ્ય સહાયક સાધનો અને સેવાઓ પણ હહન શુલ્ ક ઉપલબ્ધ છે. 833-342-7463 (TTY:711) પર કોલ કરો અથવા તમારા પરદાતા સાથે વાત કરો.

Italian: ATTENZIONE: Se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti per te. Sono disponibili anche ausili e servizi appropriati per fornire informazioni in formati accessibili, anch'essi gratuiti. Chiama il 833-342-7463 (TTY:711) o parla con il tuo fornitore.

Korean: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 833-342-7463 (TTY:711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Polish: UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 833-342-7463 (TTY:711) lub porozmawiaj ze swoim dostawcą”.

Portuguese: ATENÇÃO: Se você fala Português, serviços de assistência linguística gratuitos estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 833-342-7463 (TTY:711) ou converse com seu prestador de serviços.

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 833-342-7463 (TTY:711) или обратитесь к своему поставщику услуг.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 833-342-7463 (TTY:711) o makipag-usap sa iyong provider.”

Thai: หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-833-342-7463 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ”

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số Người khuyết tật: 833-342-7463 (TTY:711) hoặc trao đổi với người cung cấp dịch vụ của bạn.”