Pharmacy Direct Member Reimbursement Claims Form

Section 1: Member information

Section 1 instructions:

1. Complete this section fully and submit this request within the filing period which is **36 months from the date the prescription is filled**. For questions about the filing period, please call the number on the back of your member ID card;
2. If submitting a request where medications were obtained from multiple pharmacies or physicians or a request is for multiple members, please submit a separate form for each pharmacy or physician and member.

Member ID number (required):	Medicare ID number:
Date of birth (mm/dd/yyyy):	Gender:
Member name (Last, First, MI):	
Street address:	
Phone number:	
City: State:	ZIP code:
Person completing form: ☐ Member ☐ Spouse ☐ Child ☐ Other:	
Patient residence: ☐ Home ☐ Nursing home ☐ Assisted living ☐ Immediate care ☐ Hospice	
Is the member eligible for primary prescription drug coverage from another insurance provider?	☐ Yes ☐ No
If yes:	
Was the claim submitted to the other insurance provider?	☐ Yes ☐ No
Did the other insurance provider pay as the primary insurer?	☐ Yes ☐ No
Name of other insurance provider:	Member ID:

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Section 2: Pharmacy and provider information

Section 2 instructions:

1. Provide the requested information about the pharmacy where medications were received **and** the doctor that prescribed them;
2. Your pharmacy and doctor will be able to assist you if you are missing any of this information.

Pharmacy information		
Pharmacy name:	Pharmacy NCPDP or NPI:	
Street address:	Phone number:	
City:	State:	ZIP code:

Pharmacy service type:

☐ Retail ☐ Compounding ☐ Home infusion ☐ Institutional ☐ Long-term care

☐ Managed care organization ☐ Mail order ☐ Specialty

Physician information		
Physician name:	Physician NCPDP or NPI:	
Physician tax ID:	Phone number:	
Street address:		
City:	State:	ZIP code:

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Section 3: Prescription drug information

Section 3 instructions:

1. Fill out the space below completely for **each** requested medication. If any information is missing, we will be unable to process your request. Your pharmacy can provide any information you are missing;
2. Include pharmacy receipt(s) **and** proof of payment. Tape receipts to a separate page and submit with claim form. If medication was given in the emergency room or doctor's office include detailed statement.

Note: Services incurred outside the United States are not payable under Medicare plans.

Is this a compound medication? ☐ Yes ☐ No If yes, please attach compound form from pharmacy if available
Was this prescription filled outside the US? ☐ Yes ☐ No
Is this a vaccine? ☐ Yes ☐ No **If yes:** Vaccine cost: $ Admin. fee: $
National Drug Code (NDC): Drug name: Total cost: $
Fill date (mm/dd/yyyy): Rx number: Qty: Day supply:
Dosage form: Strength:
Dispense as written code (if applicable):

Is this a compound medication? ☐ Yes ☐ No If yes, please attach compound form from pharmacy if available
Was this prescription filled outside the US? ☐ Yes ☐ No
Is this a vaccine? ☐ Yes ☐ No **If yes:** Vaccine cost: $ Admin. fee: $
National Drug Code (NDC): Drug name: Total cost: $
Fill date (mm/dd/yyyy): Rx number: Qty: Day supply:
Dosage form: Strength:

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Dispense as written code (if applicable):

Is this a compound medication? ☐ Yes ☐ No
If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No
If yes: Vaccine cost: $ Admin. fee: $

National Drug Code (NDC): Drug name: Total cost: $

Fill date (mm/dd/yyyy): Rx number: Qty: Day supply:

Dosage form: Strength:

Dispense as written code (if applicable):

Is this a compound medication? ☐ Yes ☐ No
If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No
If yes: Vaccine cost: $ Admin. fee: $

National Drug Code (NDC): Drug name: Total cost: $

Fill date (mm/dd/yyyy): Rx number: Qty: Day supply:

Dosage form: Strength:

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Dispense as written code (if applicable):

Section 4: Reason for request

- ☐ Pharmacy will not accept my Humana plan
- ☐ I did not have my plan information at the time of purchase
- ☐ I was charged for medications received during an ER visit
- ☐ I believe the claim was paid incorrectly
- ☐ I received a medication while on a cruise **(Cruise itinerary must be included with request)**
- ☐ I received a Part D covered vaccine in my doctor's office
- ☐ I filled my medication during a natural disaster or state of emergency
- ☐ Other:

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Please further explain the issue:

Important claim notice

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act.

Section 5: Sign and return

Note: If this form is signed by anyone other than the member, additional documentation is required authorizing that representative. This may include an Appointment of Representative (AOR) form or statement, a Power of Attorney (POA), or other legal documentation. An AOR form is available at **Humana.com/member/documents-and-forms** for your convenience.

Member signature:	Date:

Return the completed **form** and **receipt(s)**:
Mail: Humana Pharmacy Solutions
P.O. Box 14359
Lexington, KY 40512-4359
Fax: 888-599-2730

Please note that your reimbursement amount may vary. This will depend on the difference between the amount you paid at the pharmacy, and Humana Dual Fully Integrated (HMO D-SNP) plan allowance or the rate negotiated with the pharmacy for that drug. Please be aware this means you might not receive the full amount back. If the amount you paid to the pharmacy is higher than the plan allowance, then the reimbursement will be less than what you actually paid for the drug. For more information, you can review Humana's full DMR policy in the Pharmacy coverage policies section of **https://www.humana.com/pharmacy/prescription-coverages/medicare-drug-list**.

Customer Service Information
Call toll free: 866-432-0001
TTY users call: 711
Hours of operation: Daily, 8 a.m - 8 p.m., Eastern time.