CarePlus HEALTH PLANS

Prescription Drug Claim Form

For Member Reimbursement

Claim Form Instructions

Part 1: Member Information

- 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.
- 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.

Part 2: Receipt and Prescription Drug Information

- Include all original pharmacy receipts and patient package insert(s) if applicable. Cash register receipts are not sufficient. Tape receipt(s) and patient package insert(s) to a separate page and submit with claim form.
  If medication was provided in ER or doctor's office, provide itemized statement.
- Receipt(s) must contain the information outlined under Part 2 of the claim form below.

Part 3: Pharmacy Information

- Provide information about the pharmacy or doctor's office where medications were obtained.
- Please submit a separate form for each pharmacy from which you purchase medications.

Part 4: Description of Issue

- Provide information about the reason of your request. **Note:** Prescriptions that are filled by pharmacies outside the United States and its territories are not covered; e.g., cruise ships.

If your receipt(s) and insert(s) are missing any of the required information, please ask your pharmacy or doctor's office to provide it. **Remember to keep a copy of the completed claim form and receipt(s) for your records.**

If you have any questions, please call our Member Services Department at **800-794-5907**. If you use a TTY, call **711**. You can call us seven days a week, from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**.

Once all sections have been filled in, please sign and date. Your signature attests that all information is accurately represented by the completed form and accompanying documents.

Mail the completed form, receipt(s), and patient package insert(s) to:

CarePlus Health Plans
Attention: Direct Member Reimbursement
P.O. Box 14140
Lexington, KY 40512-4140

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Part 1: Member Information

CarePlus ID Number H	Date of Birth (mm/dd/yyyy)	Medicare ID Number	Patient Residence: ☐ Home ☐ Nursing Home ☐ Assisted Living ☐ Group Home ☐ Intermediate Care ☐ Hospice
Member Last Name	First Name	MI	
Gender ☐ Male ☐ Female	Person Completing This Form ☐ Member ☐ Spouse ☐ Child ☐ Other:		
Member Street Address:			
City	State	ZIP Code	Member Telephone

Is the member eligible for primary prescription drug coverage from another insurance provider? ☐ N ☐ Y

If yes: Was the claim submitted to the other insurance provider? ☐ N ☐ Y

Did the other insurance provider pay as the primary insurer? ☐ N ☐ Y

Name of other insurance provider:	Member ID:

Part 2: Receipt and Prescription Drug Information

Ensure your receipt includes the following information:

☐ Date Filled
☐ Medication Name
☐ Medication Strength
☐ Quantity
☐ Days Supply
☐ Rx Price (including tax)
☐ Dosage Form
☐ Rx Number
☐ National Drug Code (NDC)*
☐ Physician Name
☐ Physician ID (NPI or DEA#)

**In case of compound(s), NDCs for every ingredient are listed.*

Dispense as Written (DAW): This code is a message from your doctor to the pharmacist about using generics. If it applies to your prescription, it can be found on your pharmacy label or your pharmacy can provide it.

DAW:
☐ 0 – Not Applicable
☐ 1 – Doctor mandates that brand product be dispensed
☐ 2 – Patient mandates that brand product be dispensed
☐ 5 – Brand submitted as generic
☐ 7 – Brand mandated by state law

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
Dispense as Written Code *(if applicable)*	**Quantity**	**Day Supply**	**Dosage Form Strength**

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Part 3: Pharmacy Information

Pharmacy Name		Pharmacy ID (NCPDP or NPI#)	
Pharmacy Street Address:			
City	State	ZIP Code	Pharmacy Telephone

Pharmacy Service Type:

☐ Retail ☐ Compounding ☐ Home Infusion ☐ Institutional ☐ Mail Order

☐ Long Term Care ☐ Managed Care Organization ☐ Specialty ☐ Other

Physician Information

Physician Name			Physician NCPDP or NPI
Street Address			
City	State	ZIP Code	Phone Number

Part 4: Description of Issue

☐ Pharmacy will not accept my CarePlus plan

☐ Pharmacy was unable to process my claim electronically

☐ I did not have my plan information at the time of purchase

☐ I was charged for medications received during an Emergency Room visit

☐ I believe the claim was paid incorrectly

☐ I received a medication while on a cruise (Cruise itinerary must be included with request)

☐ I was administered a Part D covered vaccine in my doctor's office

☐ I filled my medication during a natural disaster or state of emergency

☐ I have drug coverage with a plan in addition to CarePlus (Coordination of Benefits):

Name of Insurance Co.:

Insurance Co. Phone:

Employer Name:

Member ID:

Please explain the issue:

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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.

Member Signature _____ Date _____

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 **CarePlusHealthPlans.com/Resources** for your convenience.

Please note that your reimbursement amount may vary. This will depend on the difference between the amount you paid at the pharmacy, and CarePlus's 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 the Direct Member Reimbursement Policy at **CarePlusHealthPlans.com/PrescriptionDrugGuides**