Humana.

Prescription Drug Claim Form for Member Reimbursement

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:	
Member Name (Last, First, MI):	Date of Birth (mm/dd/yyyy):	
Street Address:	Phone Number:	
City:	State:	Zip Code:
Gender:	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? ◯ 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: _____

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 ◯ Manage Care Organization ◯ Mail Order ◯ Specialty		

Prescription Drug Claim Form for Member Reimbursement

Physician Information

Physician Name:	Physician NCPDP or NPI:	Physician Tax ID:
Street Address:	Phone Number:	
City:	State:	Zip Code:

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 claims 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? ◯ No ◯ Yes *If yes, please attach compound form from pharmacy if available*			
Was this prescription filled outside the US? ◯ No ◯ Yes			
Is this a vaccine? ◯ No ◯ Yes	*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? ◯ No ◯ Yes *If yes, please attach compound form from pharmacy if available*			
Was this prescription filled outside the US? ◯ No ◯ Yes			
Is this a vaccine? ◯ No ◯ Yes	*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):	

Prescription Drug Claim Form for Member Reimbursement

Is this a compound medication? ◯No ◯Yes *If yes, please attach compound form from pharmacy if available*			
Was this prescription filled outside the US? ◯ No ◯Yes			
Is this a vaccine? ◯No ◯Yes	*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? ◯No ◯Yes *If yes, please attach compound form from pharmacy if available*			
Was this prescription filled outside the US? ◯ No ◯Yes			
Is this a vaccine? ◯No ◯Yes	*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):	

If additional space is needed, you may access a blank drug information form from our website at: **https://www.humana.com/pharmacy/prescription-coverages/medicare-claim-forms**

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:_____

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 **https://www.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 14140
Lexington, KY 40512-4140

Fax: 1-866-754-5362

Please note that your reimbursement amount may vary. This will depend on the difference between the amount you paid at the pharmacy, and Humana'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 Humana's full DMR policy in the Pharmacy coverage policies section of **www.humana.com/pharmacy/prescription-coverages/medicare-drug-list.**