# HUMANA MEDICAL PLAN PRESCRIPTION DRUG CLAIM FORM FOR MEMBER REIMBURSEMENT

## CLAIM FORM INSTRUCTIONS

**Part 1: Member Information**

1. Complete all information under Part 1. Your Humana ID Number is on your member ID card.
2. Submit claim receipts within the filing period specified by your Humana plan. **You will have 36 months from the date the prescription is filled to submit your claim.** For questions about your filing period, please call the number on the back of your member ID card.
3. Please submit a separate form for each family member and pharmacy from which you purchase medications.

**Part 2: Receipt Information**

1. Include all pharmacy receipt(s) AND **proof of payment**. Tape receipts to a separate page and submit with claim form. If medication was given in Emergency Room or Doctors office include detailed statement.
2. Receipt(s) must contain the information outlined under Part 2. If your receipt(s) are missing any of this information, please ask your pharmacy to provide a printout with the information required in Part 2.
3. Remember to keep a copy of the completed claim form and receipt(s) for your records.

**Part 3: Pharmacy Information**

Provide information about the pharmacy where medications were received.

Once all sections have been filled in, please sign and date. Your signature proves that all information is truthfully represented by the completed form and accompanying receipts. If you are a representative of Member and are authorized to submit on their behalf please provide proof of Appointment of Representation.

Mail the completed form and Receipt(s) to: **Humana Pharmacy Solutions**
**P.O. Box 14140**
**Lexington, KY 40512-4140**

or Fax to: **866-754-5362**

## PART 1: MEMBER INFORMATION

Humana ID Number (required)
H☐☐☐☐☐☐☐☐ – ☐☐

Member Last Name ______ Member First Name ______ M.I. ☐

Street Address ______

City ______ State ☐☐ Zip Code ☐☐☐☐☐ Member Phone Number ( ☐☐☐ ) ☐☐☐ – ☐☐☐☐

Date of Birth (mm/dd/yyyy) ☐☐ – ☐☐ – ☐☐☐☐

Gender ☐ Male ☐ Female

Person Completing This Form ☐ Member ☐ Spouse ☐ Child ☐ Other

Patient Residence:
☐ Home
☐ Nursing Home
☐ Assisted Living
☐ Group Home
☐ Intermediate Care
☐ Hospice

## PART 2: RECEIPT INFORMATION

Ensure your receipt includes the following information:

- Date Filled
- Day(s) Supply
- Dosage Form
- Medication Name
- Medication Strength (Dose)
- National Drug Code (NDC) (XXXXX-XX-XXXX)
- Physician Name
- Physician ID (NPI or DEA #)
- Quantity
- RX Number
- RX Price (amount you paid including tax)
- If drug is a compound, list the NDCs for all ingredients and quantity of each

**HUMANA MEDICAL PLAN PRESCRIPTION DRUG CLAIM FORM FOR MEMBER REIMBURSEMENT**



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.

☐ 0 – Not Applicable ☐ 1 – Doctor requires that brand product be dispensed ☐ 2 – Patient requires that brand product be dispensed

☐ 5 – Brand submitted as generic ☐ 7 – Brand mandated by state law

## PART 3: PHARMACY INFORMATION

Pharmacy Name

Pharmacy NCPDP ID OR Pharmacy NPI

Street Address

City

State

Zip Code

Pharmacy Phone Number ( ) –

Pharmacy Service Type

☐ Retail ☐ Compounding ☐ Home Infusion ☐ Institutional ☐ Long Term Care ☐ Managed Care Organization

☐ Mail Order ☐ Specialty

## DESCRIPTION OF ISSUE

☐ Pharmacy will not accept my Humana 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 was administered a Part D covered vaccine in my doctor's office

☐ I filled my medication during an emergency

☐ I have drug coverage with a plan other than Humana (Coordination of Benefits):

Name of Insurance Co: ____________________

Insurance Co Phone: ____________________

Employer Name: ____________________

Member ID: ____________________

Please 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.

Humana ID Number H –

**HUMANA MEDICAL PLAN PRESCRIPTION DRUG CLAIM FORM FOR MEMBER REIMBURSEMENT**



**PLEASE SIGN FORM:**

**Member Signature** X________________________________ 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 https://www.humana.com/medicare-support/tools/member-forms for your convenience.

Humana is a Kentucky Medicaid MCO organization. Enrollment in any Humana plan depends on contract renewal.

## Important!

### At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, nation origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call the number on your ID card or if you use a **TTY**, call **711**.
- 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, DC 20201 **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

### Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remo interpretation, and written information in other formats to people with disabilities when such auxiliary aid and services are necessary to ensure an equal opportunity to participate.



Humana ID Number

| H | | | | | | | | | – | | |
|---|---|---|---|---|---|---|---|---|---|---|---|

## Language assistance services, free of charge, are available to you.
## Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación **(TTY: 711)**... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 **(TTY: 711)**... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị **(TTY: 711)**... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 **(TTY: 711)...** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre **(ATS: 711)**...UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet **(TTY: 711)**... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください **(TTY: 711)**...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید **(TTY: 711)...**

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló̜, námboo ninaaltsoos yézhí, bee néé ho'dólzin bikáá'ígíí bee hólne' **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك **(TTY: 711)**.

GCHK42UEN 1018