

# 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:

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Dispense as written code (if applicable):

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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?  No  Yes

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

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

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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](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 14359

Lexington, KY 40512-4140

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: 800-787-3311**

**TTY users call: 711**

**Hours of operation:** daily, 8a.m. – 8p.m, Central time.