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 **365 days 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):

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? ☐ No ☐ Yes

If yes:

Was the claim submitted to the other insurance provider? ☐ No ☐ Yes

Did the other insurance provider pay as the primary insurer? ☐ No ☐ Yes

Name of other insurance provider: Member ID:

Humana Healthy Horizons® in Virginia

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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

☐ Manage care organization ☐ Mail order ☐ Specialty

Physician information		
Physician name:		Physician NCPDP or NPI:
Physician tax ID:		
Street address:		Phone number:
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? ☐ 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):

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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:
Humana.com/pharmacy/prescription-coverages/medicare-claim-forms

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Section 4: Reason for request

- ☐ Pharmacy will not accept my Humana Healthy Horizons® in Virginia 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 **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: 866-754-5362