

## Prescription Drug Claim Form- Medicare Part D

**You are not required to use this form. You may submit other documentation that provides all of the requested information.**

<b>A. Cardholder - Patient Information</b>		<b>Today's Date:</b>		
Cardholder's Name (Last, First, MI)		Address		City
				State
				Zip Code
Cardholder ID Number	Plan Name		Patient's Date of Birth	
			/ /	
Gender <input type="checkbox"/> M <input type="checkbox"/> F				
Why was the prescription drug card NOT used for this purchase? Please explain below:				

<b>B. Other Insurance Coverage</b>			
Is patient eligible for primary prescription drug coverage from another provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>If yes, please use that insurance card to complete the fields below. Please also include a copy of the Explanation of Benefits from that provider when submitting this drug claim form.</b>			
Insured's Name (Last, First, MI)			
Other Insurance Company's Name	Member ID	PCN #	Coverage Effective Date
			/ /

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Express Scripts, Inc, its agents, or representatives.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be according to the parameters of your prescription benefit plan. It will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

Network Health Insurance Corporation is a Medicare Advantage Organization with a Medicare contract. This document is available in alternate formats. For more information, call 1-800-378-5234, Monday through Friday, 8:00 a.m. to 8:00 p.m. TTY users call 1-800-947-3529, Monday through Friday, 8:00 a.m. to 8:00 p.m.

All beneficiaries must use their plan sponsor's network pharmacies to access their prescription drug benefit, except under non-routine circumstances. Quantity limitations and restrictions may apply.

**Information for your Pharmacist/Physician:** By completing Sections C and D, you certify the information correctly represents the amount paid by the member for the prescriptions dispensed. You acknowledge that all payments related to these prescriptions will be paid to the member.

If more than three (3) prescriptions are being submitted, please complete additional claim form(s).

<b>C. Claim(s) Information</b>					
1. Is this a compound Rx? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fill Date / /	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name	Prescriber ID	
Was this prescription filled in a foreign country? <input type="checkbox"/> Yes <input type="checkbox"/> No			Prescriber Fax Number:		
2. Is this a compound Rx? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fill Date / /	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name	Prescriber ID	
Was this prescription filled in a foreign country? <input type="checkbox"/> Yes <input type="checkbox"/> No			Prescriber Fax Number:		
3. Is this a compound Rx? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fill Date / /	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name	Prescriber ID	
Was this prescription filled in a foreign country? <input type="checkbox"/> Yes <input type="checkbox"/> No			Prescriber Fax Number:		

<b>Compounds</b>			
<b>Even if you have itemized receipts, the following must be completed</b> by your pharmacist if the prescriptions being submitted for reimbursement are compound medications.			
NDC Number	Ingredient	Quantity	Cost
Compounding Fee			

<b>D. Authorization</b>				
National Provider Indicator (NPI) Number			Pharmacy Name	
Pharmacist/Physician Name	Pharmacy Address		City	State
Pharmacist/Physician Signature:				

## IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

### There are two kinds of appeals you can request:

- 1. Expedited (72 hours):** You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.
  - If your prescriber asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite your appeal.**
  - If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.
- 2. Standard (7 days):** You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

### What do I include with my appeal request?

You should include your name, address, Member number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescriber must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

### How do I request an appeal?

**For an Expedited Appeal:** You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

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Phone: 1-800-378-5234

Fax: 1-920-720-1908

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**For a Standard Appeal:** You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

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Network Health Insurance Corporation, C/O Medicare Appeals  
1570 Midway Place, P.O. Box 120  
Menasha, WI 54952

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### What happens next?

If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

### Contact information:

If you need information or help, call us at:

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Toll Free: 1-800-378-5234

TTY: 1-800-947-3529

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### Other resources to help you:

**Medicare Rights Center:**  
Toll Free: 1-888-HMO-9050

**Medicare:**  
Toll Free: 1-800- MEDICARE (1-800-633-4227)  
TTY: 1-877-486-2048

**Elder Care Locator**  
Toll Free: 1-800-677-1116



EXPRESS SCRIPTS®

P.O. Box 66752  
St. Louis, MO 63166-6752

Mailing Address Block  
Do Not Use

**Please return this claim  
form to:  
Express Scripts, Inc  
P.O. Box 66752  
St. Louis, MO 63166-6752  
ATTN: MED-D Accounts**

**Instructions for using this form:**

1. Present your prescription drug card at the pharmacy to avoid having to submit this drug claim form for reimbursement.
2. If necessary, use this form for prescription claims that were purchased without presenting your card due to an emergency or at a non-participating pharmacy. For consideration of payment, you *must* send Express Scripts all of the requested information for each claim at the address below. Express Scripts will process your claim(s) within 14 days and notify you of the determination. Express Scripts will contact you should you submit incomplete information and we are unable to obtain the information from your pharmacy or physician.
3. **Complete all items in sections (A) and (B).** Sign the form in the area provided. Enclose original receipts with this form. Be sure your itemized receipts include the following:
  - 1) Pharmacy Name
  - 2) Pharmacy NABP Number
  - 3) Prescription Number
  - 4) Date of Purchase
  - 5) Medicine Name
  - 6) Strength
  - 7) Quantity Dispensed
  - 8) Physician ID Number
  - 9) Total Amount Charged For Each Prescription

Please make copies for your records.

4. **If your claim is for a compound drug, please have your pharmacist or physician complete sections (C) and (D) of this form.**
5. **If you are not able to submit original pharmacy receipts, please have your pharmacist or physician complete sections (C) and (D) of this form.**
6. Items not covered under your prescription benefit plan should not be submitted for reimbursement including Durable Medical Equipment. Diabetic supplies requiring a prescription are reimbursable only if covered by your plan.
7. Mail completed form to:  
**Express Scripts, Inc  
P.O. Box 66752  
St. Louis, MO 63166-6752  
ATTN: MED-D Accounts**