



MEDICAL MUTUAL®

Medicare Part D Prescription Drug Claim Form

Section 1 – Cardholder Information

Cardholder # _____ Group # _____
Cardholder Name (Last, First) _____ Date of Birth _____
Street Address _____ Phone # _____
City _____ State _____ Zip _____

Section 2 – Other Prescription Drug Coverage or Situations

(Check all that apply)

- ☐ Another insurance plan has already reviewed or partially paid this claim.
(Please include the Explanation of Benefits from the other insurance plan)
- ☐ This prescription was purchased using a discount card or program. (Ex: GoodRx, InsideRx, etc.)
- ☐ Another Insurance Plan paid for this Claim in error and that Plan sent you a Collection Letter.
(Please include the collection letter with your claim)

Section 3 – Provider of the Prescription or Vaccine

Pharmacy Name _____ Pharmacy NPI _____
Street Address _____ Phone # _____
City _____ State _____ Zip _____

- ☐ My physician provided the vaccine or drug. (Include physician information here and in Section 5)

Section 4 – Reason for Purchasing Out of the Plan's Network

(Required by Medicare)

- ☐ A. I traveled outside my plan's service area and ran out of (or lost) my medication; or I became ill and could not access a network pharmacy.
- ☐ B. I was unable to obtain my medication in a timely manner within my service area (there was no network pharmacy within a reasonable driving distance that provides 24/7 service).
- ☐ C. My medication is not stocked regularly at an accessible network or mail-order pharmacy .
- ☐ D. While I was a patient in an emergency department, provider-based clinic, outpatient surgery or other outpatient facility, my medication was dispensed from an out-of-network pharmacy located in one of these institutions, and I could not get my medication filled at a network pharmacy.
- ☐ E. I received a vaccine at my doctor's office or pharmacy.
- ☐ F. I was evacuated or displaced from my residence due to a State or Federally declared disaster or health emergency.

Section 5 – Physician Information

Physician Name _____ Physician NPI _____
Physician Address _____ Phone _____
City _____ State _____ Zip _____

Section 6 – Prescription Detail

(To be completed and signed by physician or pharmacist if receipt is not attached)

Drug Name _____ NDC _____ Total Paid \$ _____
Date of Service _____ Rx # _____ Qty _____ Days Supply _____

Special Situations:

- ☐ Vaccine Claim: Drug Cost \$ _____ Admin Fee \$ _____ Total Paid \$ _____
- ☐ Compound Prescription *(Include a copy of the detailed receipt from the pharmacy showing all ingredients with costs)*
- ☐ Medication was Purchased Outside of the U.S.A. *(This includes prescriptions on a cruise ship)*
- ☐ Medication was Administered during an Emergency Room Observation Stay or at an Outpatient Facility.
(See Section 4, Option "D". Please provide a list of drugs that includes the National Drug Code (NDC) and cost for each drug)

Pharmacist/Physician Signature _____ NPI _____ Date _____

Section 7 – Cardholder Signature

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be made according to the limits of your prescription benefit plan and 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. Claims that are hard to read or incomplete may be returned or payment denied. If someone is submitting the claim on the beneficiary's behalf, an Authorization of Representation form (Form CMS-1696) or a legal document demonstrating representation must be attached. See the instructions for more information.

Warning: Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including denial of benefits, fines or imprisonment.

Signature _____ Date _____ ☐ Signed by Representative

Section 8 – How to Submit the Reimbursement Request

Reimbursement requests must be submitted in writing and may be submitted up to 36 months from the date the prescription was filled.

Via Mail: Express Scripts
ATTN: Medicare Part D
PO Box 52023
Phoenix AZ 85072

Via Online – If your plan allows it, you may be able to submit your reimbursement request online. Log in to [express-scripts.com](https://www.express-scripts.com) and navigate to: **Benefits → Forms → Start a Claim**

Instructions for Medicare Part D Prescription Drug Claim Form

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM.

Purpose

The Medicare Part D Prescription Drug Claim Form is available to help you request reimbursement as quickly as possible. While you are not required to use this form, we strongly encourage it because it includes all the information needed to process your claim.

Please print clearly. Missing, incomplete, hard-to-read, or unclear information may delay your claim.

You can use this form to request reimbursement for a routine Medicare Part D prescription that you purchased without using your benefit card as well as the following special situations:

Hospital Observation – You stayed in a hospital or outpatient facility for observation (up to three days) and could not bring your regular medicines from home. These are called “self-administered drugs.” Medicare Part D covers only self-administered drugs.

Vaccines – You received a Medicare Part D-covered vaccine. Check option “E” in **Section 4** and follow the instructions below.

- **If your doctor provided and gave you the vaccine** — Include the doctor’s bill (invoice); check the box in **Section 3** (you can leave the rest of **Section 3** blank); Complete **Section 6** and check the box for a Vaccine claim; and Complete the rest of the form
- **If a pharmacy provided and gave you the vaccine** — Include your prescription receipt; Skip **Section 5**; Complete **Section 6** and check the box for a Vaccine claim; and Complete the rest of the form.
- **If you got the vaccine from a pharmacy but your doctor injected it** — Include both the pharmacy receipt and the doctor’s bill; Complete **Section 6** and check the box for a Vaccine claim;

Important: If the vaccine was free but you paid an administration fee, that fee cannot be reimbursed.

Compound Prescriptions – A compound prescription is composed of multiple ingredients combined to form a treatment that isn’t readily available. If you are not sure whether you received a compound

prescription, ask your pharmacist.

Please note: not all plans cover compound prescriptions. Special instructions for compound prescriptions include:

- Request a **compounding receipt** from the pharmacy that lists all of the ingredients. The list should include the National Drug Code (NDC), metric quantity and cost for each ingredient. Submit the pharmacy receipt with your reimbursement request.
- Check the box for Compound Claim in **Section 6** and complete the rest of the form.

Receipts

A receipt is **required** to be reimbursed for a Medicare Part D prescription drug claim. A cash register receipt is **not** sufficient. Please include your receipt(s) with the completed claim form and keep a copy for your records. Acceptable receipts include:

Prescription Receipt – This is the receipt you get from the pharmacy. It usually includes the pharmacy name, date the prescription was filled, doctor’s name, prescription (Rx) number, drug name, National Drug Code (NDC), quantity, days’ supply, and the amount you paid. It is often attached to the outside of the prescription bag.

Doctor’s bill (physician invoice) – You will get this from your doctor if they gave you a vaccine. It should include the doctor’s name, address, and phone number, the date of service, the drug name and NDC, and the amount you paid (including any administration fee).

Hospital bill (hospital invoice) – This is an itemized bill from the hospital for your observation stay (see Section 4, Option D). Please mark the specific drugs you are requesting reimbursement for. **Only the drugs you clearly identify will be reviewed for payment.**

(continued on next page)

Section 1: Cardholder Information

Please complete this section in full. This information is needed to make sure your claim is processed under your correct benefit.

You can find your Cardholder ID and Group number on your Medicare Part D benefit card.

Section 2: Other Prescription Drug Coverage

Check any of the boxes in this Section that apply to your claim.

Section 3: Pharmacy Information

Please provide as much information as possible about the pharmacy where the drug or vaccine was purchased, including the National Provider Identifier (NPI) number. The NPI should be on the prescription drug receipt. Otherwise, the pharmacy can provide it.

Section 4: Out-of-Network Purchase

Please check the reason that best applies to your situation. This is required by Medicare.

Section 5: Physician Information

Please complete this section with all requested information. This information is needed to process your claim according to Medicare guidelines.

You may need to contact your doctor's office to get their address, phone number, and National Provider Identifier (NPI). If this information is not provided, your claim may be denied.

Section 6: Prescription Detail

Complete this section with information from your pharmacy prescription receipt. As an alternative to a receipt, you can have your doctor or pharmacist complete and sign this section.

Special Situations – Check any that may apply to your claim and provide the information or documentation that is requested.

Section 7: Cardholder Signature

Please sign the claim form.

If someone is submitting the claim for you, check

the “Signed by Representative” box. If signed by a representative, one of the following must be provided:

- An Authorization of Representation form (Form CMS-1696), or
- Another legal document that shows the person is allowed to act for you

You can get Form CMS-1696 at [cms.gov](https://www.cms.gov) or by calling the Customer Service number on your benefit card.

Section 8: Submit the Claim

The claim **must** be submitted in writing. It may be submitted via mail to or online as shown in this Section.

Please note: Reimbursement requests may be submitted up to 36 months from the date the prescription was filled and they must be submitted in writing.