

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.

A. Cardholder - Patient Information		Today's Date:				
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. Other Insurance Coverage			
Is patient eligible for primary prescription drug coverage from another provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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.			
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.

UCare Minnesota and UCare Wisconsin, Inc. are health plans with Medicare contracts.

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.

H2456_091211_2 DHS Approved (09192011) CMS Approved (10272011)
 H2459 H4270_091211_2 CMS Approved (10272011)
 H2459 H4270 Group_091211_2 IA (09122011)

U3438A (10/11)

Information for your Pharmacist/Doctor: 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).

C. Claim(s) Information					
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:		

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

D. Authorization				
National Provider Indicator (NPI) Number			Pharmacy Name	
Pharmacist/Doctor Name	Pharmacy Address		City	State Zip Code
Pharmacist/Doctor Signature:				



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 doctor.
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 doctor complete sections (C) and (D) of this form.**
5. **If you are not able to submit original pharmacy receipts, please have your pharmacist or doctor 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**

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can request:

- 1. Fast (72 hours):** You, your prescriber, or your representative can request a 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 a fast appeal if you are asking us to pay you back for a prescription drug you already received. If your request for a fast is granted, we must give you a decision no later than 72 hours after we get your appeal.
 - If your prescriber asks for a fast 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 give you a fast appeal.**
 - If you ask for a fast appeal without support from your prescriber, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast 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 a Fast Appeal: You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

Phone: 612-676-6841 or 1-877-523-1517 TTY: 612-676-6810 or 1-800-688-2534	Fax: 612-884-2021 or 1-866-283-8015
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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:

Mailing address: UCare Complaints, Appeals, and Grievances P.O. Box 52 Minneapolis, MN 55440-0052	Street address: 500 Stinson Blvd. NE Minneapolis, MN 55413
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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:

Toll Free: 1-877-523-1517	TTY: 1-800-688-2534
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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