REQUEST FOR MEDICARE PART D COVERAGE DETERMINATION REIMBURSEMENT

We are pleased to be your Medicare prescription drug plan. Please use this form when you want to be reimbursed for a covered prescription drug that you have paid for out of pocket. Refer to the following guidelines when submitting your request.

- Tape your original receipts in the boxes marked for receipts. **Cash register receipts do not provide enough information and are not acceptable.**
- Keep copies of receipts for your records.
- If you have other insurance that is primary over our coverage an Explanation of Benefits (EOB) from the primary insurance must be submitted with this claim form. The retail cost of the medication and the amount you paid are required to process secondary claims.
- Sign the completed form at the bottom of the second page and mail to:

  Pharmacy Services
  PO Box 13249 M/S CS02
  Salem, OR 97309-1249

- To contact Customer Service please call the phone number on the back of your member ID card, TTY users should call 711; or refer to your Evidence of Coverage for questions or full benefit information.

  Hours: 8:00 a.m. to 8:00 p.m., 7 days a week (Oct 1 - Feb 14)
  8:00 a.m. to 8:00 p.m., Monday - Friday (Feb 15 - Sep 30)

Prescription Information

IMPORTANT:

All prescription claims must have prescription receipts from the pharmacy attached which include:

● Pharmacy Name/Address	● Drug Name, Strength and National Drug Code (NDC)	● Quantity and Days Supply
● Member Name	● Date Filled	● Price
● Prescription Number	● Physician's Identifier (National Provider Identifier)	

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Member/Requestor Information

Member Name _____ Member Date of Birth _____

Member Plan ID Number _____ Member Phone Number _____

Mailing Address (payments will be mailed to this address) _____

Requestor's Name (if not member) _____ Requestor's Phone Number _____

Requestor's relationship to member (attach documentation that shows authority to represent member). _____

Other Coverage Information

Do you have any other prescription coverage? If yes, please provide all of the following information that you will find on the other coverage ID card.

ID Number for other insurance _____

Rx BIN for other insurance _____

Rx PCN for other insurance _____

IMPORTANT:
If you provided other coverage information and the other coverage is primary to Medicare, EOB receipts from the primary insurance must be submitted with this claim.

Please indicate the number of receipts attached _____

I hereby certify that all information given is correct. I further certify that all items were purchased for the above named member. I understand that it is a crime to knowingly provide false or misleading information and that doing so may result in civic or criminal prosecution.

▶ _____ _____

Signature Date

TAPE ORIGINAL RECEIPT HERE

In date order

Cash register receipts do not provide enough information and are not acceptable.

Keep copies for your records.

Check all that apply:

- ☐ At the time this prescription was filled I was a resident in a long-term care facility.
- ☐ At the time this prescription was filled I was a resident of an assisted living facility.
- ☐ This prescription is for home infusion therapy.

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