MEDICARE PART D PRESCRIPTION DRUG REIMBURSEMENT CLAIM FORM

Use this form to ask our plan for a Medicare Part D Prescription Drug reimbursement. Please read carefully and complete all sections of this form. You, or your authorized representative can make this request. For instructions, see page 2 of this form.

Enrollee Information		
Identification Number (refer to your plan card):	Date of Birth (MM/DD/YYYY):	
Name (Last, First, MI):		
Street Address:		
City:	State:	Zip Code:
Phone Number:		

If the person making this request isn't the plan enrollee:

Requestor's Name (Last, First, MI):		
Relationship to plan enrollee		
Street Address:		
City:	State:	Zip Code:
Phone Number:		
☐ Submit documentation with this form showing your authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or equivalent). For more information on appointing a representative, contact our plan or call 1-800-MEDICARE. (1-800-633-4227). TTY users can call 1-877-486-2048.		

Instructions

Complete this form for each claim and include the prescription label receipt (this receipt is provided by the pharmacy) and a proof of payment receipt (cash register receipt). The following information is required to process your claim. You can locate the information on the prescription label receipt, or you may ask your pharmacy to complete the information.

1. Prescription (Rx) Number
2. National Drug Code (NDC Number)
3. Fill Date
4. Drug Name
5. Quantity
6. Days Supply
7. Total Paid ($ Amount)
8. Prescriber Name
9. Prescriber National Provider Identifier Number (NPI)
10. Pharmacy Name
11. Pharmacy National Provider Identifier Number (NPI)

Please note that missing, incomplete or hard-to-read documentation and/or information can delay the successful processing of your claim. Reimbursements of submitted claims are subject to plan terms and conditions and not guaranteed. The amount of reimbursement may be reduced from the submitted amounts based on plan cost and copayments.

How to submit this form

Submit this form and receipts by mail or fax:

Address:
MedImpact Healthcare Systems
PO Box 509108
San Diego, CA 92150-9108

Fax Number:
1-858-549-1569

If you need help completing this form, call at 1-866-494-3927 (toll-free). (TTY users call 711). We are available 24 hours a day, seven days a week. Calls to this number are free.

Reason for Request	
☐ Did not have plan card at the time of purchase	☐ Medicare Prescription Payment Plan (MPPP) retroactive election
☐ Filled as a result of a federal or state of emergency/natural disaster	☐ Filled while waiting for drug approval
☐ Filled at an out-of-network pharmacy	☐ Pharmacy unable to process claim electronically
☐ Coordination of Benefits (COB) Claim Plan Name: _____ ID Number: _____	☐ Other (explain below)
☐ Incorrect Co-pay	

Prescription Information

Prescription #1			
Prescription (Rx) Number	National Drug Code (NDC Number)		Fill Date
Drug Name	Quantity	Days Supply	Total Paid ($ Amount)
Prescriber Name	Prescriber National Provider Identifier Number (NPI)		
Pharmacy Name	Pharmacy National Provider Identifier Number (NPI)		

Prescription #2			
Prescription (Rx) Number	National Drug Code (NDC Number)		Fill Date
Drug Name	Quantity	Days Supply	Total Paid ($ Amount)
Prescriber Name	Prescriber National Provider Identifier Number (NPI)		
Pharmacy Name	Pharmacy National Provider Identifier Number (NPI)		

Prescription #3			
Prescription (Rx) Number	National Drug Code (NDC Number)		Fill Date
Drug Name	Quantity	Days Supply	Total Paid ($ Amount)
Prescriber Name	Prescriber National Provider Identifier Number (NPI)		
Pharmacy Name	Pharmacy National Provider Identifier Number (NPI)		

Prescription #4			
Prescription (Rx) Number	National Drug Code (NDC Number)		Fill Date
Drug Name	Quantity	Days Supply	Total Paid ($ Amount)
Prescriber Name	Prescriber National Provider Identifier Number (NPI)		
Pharmacy Name	Pharmacy National Provider Identifier Number (NPI)		

MedImpact

Additional information we should consider:

_____

_____

_____

_____

IMPORTANT! A signature is REQUIRED

In accordance with the dispositions of Act 230 of August 9th, 2008, provides the following: "Any person who knowingly and with the intention to defraud present false information in an insurance request or, presents, or help or make a fraudulent complaint for the payment of a loss or benefit, or presents more than one claim for the same damage or loss, will commit a serious crime and if convicted, will be sanctioned for each violation with a fine no less than five thousand ($5,000) dollars, nor greater of ten thousand ($10,000) dollars or imprisonment by a fixed term of three (3) years, or both. If aggravating circumstances exist, the term of imprisonment could be increased up to a maximum of five (5) years; if mitigating circumstances mediate, it could be reduced a minimum of two (2) years."

I certify that I have received the medicine described herein and that the plan participant named is eligible for Medicare Part D Prescription Drug Benefit. I certify that I have read and understood this form, and that all the information entered on this form is true and correct. I also certify that the claim(s) being submitted for payment is not for treatment of an on-the-job injury. I authorize release of all information pertaining to this claim(s) to GlobalHealth (HMO), the plan administrator, underwriter, sponsored policyholder, and/or employer.

Enrollee or Authorized Representative Signature:	**Date:**

GlobalHealth is an HMO plan offered by GlobalHealth, Inc.

Confidentiality Notice: This communication is privileged and confidential, and/or protected health information (PHI) or electronic protected health information (ePHI), and may be subject to protection under the law, including HIPAA. This communication is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, be advised that any use, disclosure, distribution, copying, or action taken in reliance on the contents of this communication is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for its return.

Notice of availability of language assistance services

and auxiliary aids and services

English: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-280-5555 (TTY 711).

Español: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-844-280-5555 (TTY 711).

Chinese: 如果您會說中文，我們可以為您提供免費語言幫助服務。也免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打 1-844-280-5555 (TTY 711) 。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Ang naaangkop na mga pantulong na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang walang bayad. Tumawag sa 1-844-280-5555 (TTY 711).

French: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-280-5555 (TTY 711).

Vietnamese: Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Các hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Gọi 1-844-280-5555 (TTY 711).

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Auch entsprechende Hilfsmittel und Services zur Bereitstellung von Informationen in barrierefreien Formaten stehen kostenlos zur Verfügung. Rufen Sie 1-844-280-5555 (TTY 711) an.

Korean: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 지원 및 서비스도 무료로 제공됩니다. 1-844-280-5555 (TTY 711) 로 전화하세요.

Russian: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по номеру 1-844-280-5555 (TTY 711).

Arabic: إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك. المساعدات والخدمات المساعدات تتوفر مجانًا إليها الوصول يمكن بتنسيقات المعلومات لتوفير المناسبة. بالرقم اتصل 1-844-280-5555 (TTY 711).

Italian: Se parli italiano, sono a tua disposizione servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-844-280-5555 (TTY 711).

Portuguese: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-844-280-5555 (TTY 711).

French Creole: Si w pale kreyòl franse, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib tou gratis. Rele 1-844-280-5555 (TTY 711).

Polish: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Odpowiednie pomoce pomocnicze i usługi umożliwiające dostarczanie informacji w przystępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-844-280-5555 (TTY 711).

Hindi: यदि आप हिंदी बोलते हैं, तो मुफ्त भाषा सहायता सेवाएं आपके लिए उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक एड्स और सेवाएं भी नि: शुल्क उपलब्ध हैं। कॉल 1-844-280-5555 (TTY 711).

Japanese: 日本語を話せる場合は、無料の言語支援サービスをご利用いただけます。アクセシブルな形式で情報を提供するための適切な補助援助やサービスも無料で利用できます。 1-844-280-5555 (TTY 711) に電話します。