# MEDICARE PRESCRIPTION DRUG CLAIM FORM

**INSTRUCTIONS**

- To process your claim as quickly as possible, please provide all information requested.
- Ask your pharmacist for the drug information on this form. Prescription receipts or a pharmacy-generated drug summary must be attached. Cash register receipts are not acceptable.
- Find your identification number on your member ID card.
- Use a separate claim form for each patient and pharmacy.
- If you are submitting more than two prescription claims, please use a new claim form.
- Fill out all fields for each submitted prescription.
- NPI – National Provider Identifier – a 10-digit identification number assigned to health care providers.

**Example of how to complete the Prescription Drug Claim Form**

**1** Rx Number 000006011481

Date Filled 10/01/2013

Quantity 60 Day Supply 30

Name of Medication "Drug Name"

NDC Number 00186502228

NPI Number 9215241163

Prescription Cost $ 146.04

Balance Due $ .

- If additional claim forms are needed, call Member Services at the number listed on the back of your member ID card.
- Mail your completed claim form and prescription receipts to:
  Itasca Medical Care
  1219 SE 2rd Ave
  Grand Rapids, MN 55744

If you need information or help, call us at:

Toll Free: **1-800-843-9536**
TTY: **1-800-627-3529** or **711**
Hours: October 1 – February 14, 7 days a week, 8 a.m. – 8 p.m.; February 15 – September 30, Monday – Friday, 8 a.m. – 8 p.m.

Other resources to help you:

**1-800-MEDICARE** (**1-800-633-4227**)
TTY/TDD: **1-877-486-2048**, available 24 hours/day, 7 days/week except federal holidays

**CLAIM SUBMISSION**

- DO NOT include charges for durable medical equipment. DO NOT submit canceled checks. DO NOT submit cash register slips. These are not acceptable as substitutes for original receipts. DO NOT submit statements with balance amounts only.

**HOW TO COMPLETE THIS FORM**

- Your member ID number can be found on your member ID card.
- Sign and date in the space provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send in your claim(s). No documents will be returned.

**COMPOUND INFORMATION**

- If a compound prescription, enter the NDC number for the most expensive ingredient.

**COMPOUND PRESCRIPTIONS**

For pharmacy use only

| NDC number | Drug ingredient | Quantity | Charge |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**I certify that:**

The information on this form is correct. The member listed here is eligible for benefits and has received these medications. I approve the release of information on this form to Itasca Medical Care & CareMark. I agree that any benefits payable here for prescription drugs are not assignable. I agree that any further assignment shall be void. I also state that there has been no assignment of these benefits.

X ______________________________
Member Signature

______________________________
Date

Health Care Fraud Notice - Fraud Hotline at **1-800-706-4071**. TTY/TDD **1-800-693-3816**. Monday through Friday, 8 a.m. to 5 p.m. CT. Health care fraud affects us all and causes an increase in health care costs. If you know or suspect any type of health care insurance fraud, please call us at the fraud hotline. All calls are confidential. You may report your concerns anonymously via our toll-free hotline.

IMCare Classic (HMO SNP) is a health plan that contract with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in IMCare Classic (HMO SNP) depends on contract renewal.

# MEDICARE PRESCRIPTION DRUG CLAIM FORM

## MEMBER INFORMATION

Date of Birth ☐☐/☐☐/☐☐☐☐

Identification (ID) Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last)

Street Address

City State ZIP

## OTHER HEALTH INSURANCE INFORMATION

Is this medication for an on-the-job injury? . . . . . . . . ☐ Yes ☐ No

Is this medication related to an auto accident? . . . . . ☐ Yes ☐ No

Do you have other insurance that includes prescription drug coverage? . . . . . . . . . . . . . . . . . . . . . ☐ Yes ☐ No

If yes, please submit claim form with **both** items below:

1. Copy of both sides of other health insurance ID card
2. Explanation of Benefits (EOB) from other health insurance. Please include amount paid and/or rejection of these prescriptions.

Was an out-of-network pharmacy used? . . . . . . . . . . ☐ Yes ☐ No

If yes, provide reason below:

☐ I was traveling within the United States, but outside of the Plan's service area. I became ill or lost or ran out of my prescription drugs.

☐ I was unable to get a covered drug in a timely manner. There was not a network pharmacy nearby that provided 24/7 service.

☐ I was trying to fill a covered drug not regularly stocked at a network retail or mail order pharmacy. (This might include orphan drugs or specialty pharmaceuticals.)

☐ I was a patient in one of these:
- Emergency department
- Provider-based clinic
- Outpatient surgery
- Other outpatient setting

## PHARMACY INFORMATION

Pharmacy Name

Pharmacy Address

City State ZIP

## PRESCRIPTION CLAIM INFORMATION

**Original pharmacy receipts are required. Do not staple.**

Is this prescription claim for a compound medication? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ☐ Yes ☐ No

Note: If yes, make sure your pharmacist lists the NDC number for the active ingredient.

Receipts must include:

| | | |
|---|---|---|
| ✓ Pharmacy name | ✓ Strength | ✓ Drug name |
| ✓ Date purchased | ✓ Quantity | ✓ Drug charge |
| ✓ NDC number | ✓ Days supply | ✓ NPI number |
| ✓ Prescription number | ✓ OHI Paid Amount (if COB) | |

All fields below must be completed.
Call your pharmacist if you need assistance.

**1** Rx Number ☐☐☐☐☐☐☐☐☐☐☐☐

Date Filled ☐☐/☐☐/☐☐☐☐

Quantity ____________ Day Supply __________

Name of Medication ____________________

NDC Number ☐☐☐☐☐☐☐☐☐☐☐

NPI Number ☐☐☐☐☐☐☐☐☐☐

Prescription Cost $ ☐☐☐☐ . ☐☐

Balance Due $ ☐☐☐☐ . ☐☐

**2** Rx Number ☐☐☐☐☐☐☐☐☐☐☐☐

Date Filled ☐☐/☐☐/☐☐☐☐

Quantity ____________ Day Supply __________

Name of Medication ____________________

NDC Number ☐☐☐☐☐☐☐☐☐☐☐

NPI Number ☐☐☐☐☐☐☐☐☐☐

Prescription Cost $ ☐☐☐☐ . ☐☐

Balance Due $ ☐☐☐☐ . ☐☐

This information is available in other forms to people with disabilities by calling:

TOLL FREE
Member Services: 1-800-843-9536

TOLL FREE MINNESOTA RELAY
TTY, Voice, ASCII, or Hearing Carry Over: 1-800-627-3529 or 711

TOLL FREE SPEECH-TO-SPEECH RELAY SERVICE
1-877-627-3848

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**Member Services**
**1-800-843-9536**

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

ចំណាប់អារម្មណ៍ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທີງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0012 (3-13)

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Itasca Medical Care will enroll all eligible people who select or are assigned to Itasca Medical Care without regard to physical or mental condition, health status, need for health services, claims experience, medical history, genetic information, disability, marital status, age, sex, sexual orientation, national origin, race, color, religion, or political beliefs. Itasca Medical Care will not use any policy or practice that has the effect of such discrimination.

American Indians can continue or begin to use tribal and Indian Health Service (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older, this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.