



Medicare Part D Prescription Drugs Claim Form

Claim Form Instructions



Please read carefully before completing this form. **Claim forms that do not include the required information may delay or inhibit our ability to process your request for reimbursement. Completion and submission of this form does not guarantee reimbursement. Claims are subject to limitations, exclusions, and other provisions of your benefit plan.**

Part 1: Member Information (to be completed by the member)

1. Complete all information under Part 1. The member/cardholder ID Number is located on your insurance card.
2. Submit claims within the filing period specified by your health plan. For questions about your filing period, please call the number on the back of your insurance card.
3. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.
4. **IMPORTANT NOTE: Payment and related correspondence will be sent to the primary subscriber unless you provide us with an Alternate Address in Part 1.**

Part 2: Receipt

1. Submit prescription receipts/labels that contain the requested information (shown below) or have your pharmacist complete Part 2 and Part 3. If you do not receive a receipt for your prescription(s), pharmacist signature is required.
2. Include all original pharmacy receipt(s). Tape receipts to a separate page to be submitted with the claim form.
Note: Please do not staple receipts or other documentation to the claim form.
3. For multiple claims, please use the multiple prescription form.

PRESCRIPTION/PHARMACY INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information. Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234 123 Any Street Home Town, US 12345-6789	(509)555-1234 Store NPI: 1234567890
RX 1234567	Date Filled: 1/1/2009
DOE, JANE DOB: 01/01/1900 456 Home Road Home Town, US 12345	(509)555-5678
Amoxicillin 500 mg capsules (Teva) 00000-1111-22 QTY: 45	DAW: 0 Days Supply: 30
A. SMITH, MD NPI: 4567890123	
U&C: 200.00	COPAY: 20.00

1. Date Filled*
2. RX Number
3. Quantity*
4. Day Supply*
5. National Drug Code (NDC)*
6. Medication Name and Strength*
7. Physician Name
8. Physician National Provider ID (NPI)
9. DAW
10. Usual and Customary Price (U&C)/RX Price*
11. Copay*
12. Pharmacy National Provider ID (NPI)

** Denotes information required to process a claim. If this information is not included, it may delay or inhibit our ability to process your request for reimbursement.*

4. Remember to keep a copy of the completed claim form and receipt(s) for your records.
5. Send the completed form and receipt(s) to:

Doctors Healthcare Plans, Inc.
Attn: Pharmacy Department
2020 Ponce De Leon Blvd., PH 1
Coral Gables, FL 33134
Fax: 858-357-2614



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Medicare Part D Prescription Drugs Claim

PART 1

*Indicates required information

Primary Subscriber/Cardholder ID Number*		Group Number	
Name of Health Plan/Insurance		Primary Subscriber Name*	DOB: (mm/dd/yyyy)* / /
Member Name: (First, Middle, Last)*		Date of Birth: (mm/dd/yyyy)* / /	Relationship to Primary Subscriber Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>
Primary Subscriber Address: (Street, City, State, Zip code)			
Alternate Address: (Street, City, State, Zip code)			
*If no alternate address is specified, correspondence and/or payment will be forwarded to the primary subscriber address on file with your health plan/insurance.			
Member Telephone Number: ()			

Indicate reason for manually filing these claims (select one):

<input type="checkbox"/> Coordination of Benefits – Claims must be submitted with pharmacy receipt(s) identifying copays paid and an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary insurance payment)
<input type="checkbox"/> Discount Card was used
<input type="checkbox"/> Health plan/insurance information or insurance card not available at the time of purchase
<input type="checkbox"/> Pharmacy not participating in network
<input type="checkbox"/> Pharmacy unable to process claim electronically
<input type="checkbox"/> Emergency – If Emergency, describe emergency below

Manual submission of claims does not guarantee reimbursement.

Describe Emergency: _____

PART 2

RX Number	Date Filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*
Medication Name and Strength *			Physician Name & NPI Number Name: _____ NPI : _____		RX Price* \$
					Co-Pay* \$

Compound? Yes No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

PART 3

Affix Pharmacy Label Here or Enter the Required Information:

Pharmacy Name*			Pharmacy Telephone Number	
Street Address			NPI*	
City	State	Zip	Pharmacist Signature*	Date*

By signing below, I certify that I have read and understood this form, and that the information provided on this form is true and correct to the best of my knowledge.

Member or Authorized Representative Signature* _____

Date* _____

NOTE: If this form is completed and signed by an Authorized Representative, an Authorization of Representation (AOR) must accompany this form.



Medicare Part D Prescription Drug Claim Form

Multiple Prescription Claim Form

* Indicates required information

RX Number	Date Filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name NPI		RX Price* \$	Co-Pay* \$

Compound? Yes No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name NPI		RX Price* \$	Co-Pay* \$

Compound? Yes No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name NPI		RX Price* \$	Co-Pay* \$

Compound? Yes No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name NPI		RX Price* \$	Co-Pay* \$

Compound? Yes No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name NPI		RX Price* \$	Co-Pay* \$

Compound? Yes No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name NPI		RX Price* \$	Co-Pay* \$

Compound? Yes No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name NPI		RX Price* \$	Co-Pay* \$

Compound? Yes No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)* [][][][][][][][][][][][][][][]	
Medication Name and Strength *			Physician Name & NPI Number Name NPI		RX Price* \$	Co-Pay* \$

Compound? Yes No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)



Medicare Part D Prescription Drugs Claim

COMPOUND PRESCRIPTIONS

The pharmacy or dispensing facility must complete the remaining portion of this form and return it to the member/patient or provide the member/patient with a Universal Claim Form for a Compounded Medication.*

- Provide an 11-digit NDC number for each of the ingredient(s) in the medication
- Indicate the drug ingredient(s) and quantity.
- Indicate the metric quantity dispensed in number of tablets, grams or milliliters for liquids, creams, ointments or injectables.
- Indicate the amount paid for the prescription by the patient.

Compound Prescriptions			
For pharmacy use only*			
Total Charge:			\$

Note: If the medication/drug was purchased in a foreign country, the currency must be converted into US dollars.

The original pharmacy prescription label or cash receipt should accompany this claim form or the Universal Claim Form for a compounded medication. Prescription labels and receipts will not be returned; you may wish to make copies for your records.



Medicare Part D Prescription Drugs Claim

IMPORTANT CLAIM NOTICE

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 786-460-3427 o 833-342-7463(TTY: 711).

AL, AK, AZ, CT, DE, GA, ID, IL, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OR, RI, SC, SD, VT, WI, WY Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties. **Additionally, DE, ID, MN, NM, OH Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or criminal penalties.

AR, CA, DC, FL, HI, MD, ME, OK, TN, TX, UT, VA, WA, WV Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information is guilty of a crime and may be subject to imprisonment, fines, and/or denial of insurance benefits. **Additionally, AR, CA, FL, MD, OK, TX, UT, WV Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or confinement in prison.

DISCRIMINATION IS AGAINST THE LAW

Doctors HealthCare Plans, Inc. complies with applicable civil rights laws and does not discriminate or exclude individuals on the basis of race, color, national origin, age disability, sex, sexual orientation, pregnancy, gender, gender identity, or religion.

Doctors HealthCare Plans, Inc. provides: (1) free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and, (2) free language services to individuals whose primary language is not English, such as, qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your ID Card. If you believe that Doctors HealthCare Plans, Inc., has failed to provide these services or discriminated in any way, you can file a grievance with:

Doctors HealthCare Plans, Inc., Attention: Member Services Department, 2020 Ponce de Leon Blvd., PH 1, Coral Gables, FL 33134 or call (786) 460-3427 or (833) 342-7463, TTY:711; 7 days a week; 8AM to 8PM EST.

You can file a grievance by calling, in person or by mail. If you need help filing a grievance, our Member Services Representatives are available to help you at the number listed above. You can also file a civil rights complaint electronically through the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or call (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

MULTI-LANGUAGE INTERPRETER SERVICE

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (833) 342-7463 (TTY:711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (833) 342-7463 (TTY:711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务,帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务,请致电 (833) 342-7463 (TTY:711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問,為此我們提供免費的翻譯服務。如需翻譯服務,請致電 (833) 342-7463 (TTY:711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamat. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa (833) 342-7463 (TTY:711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (833) 342-7463 (TTY:711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi (833) 342-7463 (TTY:711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (833) 342-7463 (TTY:711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (833) 342-7463 (TTY:711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (833) 342-7463 (TTY:711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (833) 342-7463 (TTY:711). سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (833) 342-7463 (TTY:711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (833) 342-7463 (TTY:711). Irá encontrar alguém que fale idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (833) 342-7463 (TTY:711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (833) 342-7463 (TTY:711). Ta usługa jest bezpłatna.

Hindi: हमारे सवा य या दवा की योजना के बारे में आपके किसी भी परन के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया परापत करने के लिए, बस हमों (833) 342-7463 (TTY:711) पर फोन करें. कोई व्द्विक्त जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、(833) 342-7463 (TTY:711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。