VILLAGECAREMAX

SEE WHAT'S POSSIBLE WHEN HEALTH CARE GETS PERSONAL.

Dear *Member,*

Enclosed is your *Medicare Part D Prescription Drug Claim* form. To ensure no delays in processing please follow the instructions below:

1. Fill out the form in full.
2. Please complete Part 1 - the Member Information and Part 2 - attach the original prescription receipt to a separate sheet of paper to be submitted with the claim form. Remember to keep a copy for yourself.
3. *Mail the form to:*

   Mail: MedImpact Healthcare Systems Inc. PO Box 509108 San Diego CA 92150-9180

   Fax: 858-549-1569

   Email: Claims @medimpact.com

If you have any questions or need additional help with filling out this form, *please call our Member Services Department at 1-800-469-6292 (TTY 711), 7 days a week from 8:00 am to 8:00 pm.*

VillageCareMAX Member Services

OR

Your VillageCareMAX Team

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 (509)555-1234
123 Any Street **Store NPI: 1234567890**
Home Town, US 12345-6789

RX 1234567 **Date Filled: 1/1/2009**

DOE, JANE DOB:
01/01/1900
456 Home Road (509)555-5678
Home Town, US 12345

Amoxicillin 500 mg capsules (Teva) **DAW: 0**
00000-1111-22 **QTY: 45** **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:

MedImpact Healthcare Systems, Inc.
PO Box 509108
San Diego, CA 92150-9108
Fax: 858-549-1569
E-mail: Claims@Medimpact.com

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 ☐ Spouse ☐ Dependent ☐
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):

- ☐ 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)
- ☐ Discount Card was used
- ☐ Health plan/insurance information or insurance card not available at the time of purchase
- ☐ Pharmacy not participating in network
- ☐ Pharmacy unable to process claim electronically
- ☐ Emergency – If Emergency, describe emergency below

Manual submission of claims does not guarantee reimbursement.

Describe Emergency: _____

PART 2

RX Number	Date Filled* / /	New ☐ Refill ☐ (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*

I understand that anyone who knowingly or intentionally misrepresents, omits, or falsifies information requested by this form may be found guilty of a crime, and/or subjected to civil or criminal penalties. 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

Must be attached to a Commercial or Part D Prescription Drug form

* Indicates Required Information

RX Number	Date Filled* / /	New ☐ Refill ☐ (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 ☐ Refill ☐ (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 ☐ Refill ☐ (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 ☐ Refill ☐ (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 ☐ Refill ☐ (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 ☐ Refill ☐ (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 ☐ Refill ☐ (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 Claim Form

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.