Humana

MEDICARE PRESCRIPTION DRUG CLAIM FORM FOR MEMBER REIMBURSEMENT

CLAIM FORM INSTRUCTIONS

Part 1: Member Information

1. Complete all information under Part 1. Your Humana ID Number is on your member ID card.
2. Submit claim receipts within the filing period specified by your Humana plan. **You will have 36 months from the date the prescription is filled to submit your claim.** For questions about your filing period, please call the number on the back of your member ID card.
3. Please submit a separate form for each family member and pharmacy from which you purchase medications.

Part 2: Receipt Information

1. Include all pharmacy receipt(s) AND **proof of payment**. Tape receipts to a separate page and submit with claim form. If medication was given in Emergency Room or Doctors office include detailed statement. Note: Services incurred outside the United States are not payable under Medicare plans.
2. Receipt(s) must contain the information outlined under Part 2. If your receipt(s) are missing any of this information, please ask your pharmacy to provide a printout with the information required in Part 2.
3. Remember to keep a copy of the completed claim form and receipt(s) for your records.

Part 3: Pharmacy Information

Provide information about the pharmacy where medications were received.

Once all sections have been filled in, please sign and date. Your signature proves that all information is truthfully represented by the completed form and accompanying receipts. If you are a representative of Member and are authorized to submit on their behalf please provide proof of Appointment of Representation.

Mail the completed form and Receipt(s) to: **Humana Pharmacy Solutions**
P.O. Box 14140
Lexington, KY 40512-4140

or Fax to: **866-754-5362**

PART 1: MEMBER INFORMATION

Humana ID Number (required) H _____ – _____

Medicare ID Number _____

Patient Residence:
- ☐ Home
- ☐ Nursing Home
- ☐ Assisted Living
- ☐ Group Home
- ☐ Intermediate Care
- ☐ Hospice

Member Last Name _____

Member First Name _____ M.I. _____

Street Address _____

City _____ State _____ Zip Code _____

Member Phone Number (_____) _____ – _____

Date of Birth (mm/dd/yyyy) _____ – _____ – _____

Gender ☐ Male ☐ Female

Person Completing This Form ☐ Member ☐ Spouse ☐ Child ☐ Other

PART 2: RECEIPT INFORMATION

Ensure your receipt includes the following information:

- Date Filled
- Day(s) Supply
- Dosage Form
- Medication Name
- Medication Strength (Dose)
- National Drug Code (NDC) (XXXXX-XX-XXXX)
- Physician Name
- Physician ID (NPI or DEA #)
- Quantity
- RX Number
- RX Price (amount you paid including tax)
- If drug is a compound, list the NDCs for all ingredients and quantity of each

Dispense as Written (DAW): This code is a message from your doctor to the pharmacist about using generics. If it applies to your prescription, it can be found on your pharmacy label or your pharmacy can provide it.

☐ 0 – Not Applicable ☐ 1 – Doctor requires that brand product be dispensed ☐ 2 – Patient requires that brand product be dispensed

☐ 5 – Brand submitted as generic ☐ 7 – Brand mandated by state law

PART 3: PHARMACY INFORMATION

Pharmacy Name

Pharmacy NCPDP ID

OR

Pharmacy NPI

Street Address

City

State

Zip Code

Pharmacy Phone Number ( ) –

Pharmacy Service Type

☐ Retail ☐ Compounding ☐ Home Infusion ☐ Institutional ☐ Long Term Care ☐ Managed Care Organization

☐ Mail Order ☐ Specialty

DESCRIPTION OF ISSUE

☐ Pharmacy will not accept my Humana plan

☐ Pharmacy was unable to process my claim electronically

☐ I did not have my plan information at the time of purchase

☐ I was charged for medications received during an Emergency Room visit

☐ I believe the claim was paid incorrectly

☐ I was administered a Part D covered vaccine in my doctor's office

☐ I filled my medication during an emergency

☐ I have drug coverage with a plan other than Humana (Coordination of Benefits):

Name of Insurance Co: _____

Insurance Co Phone: _____

Employer Name: _____

Member ID: _____

Please explain the issue:

_____

_____

_____

_____

_____

_____

IMPORTANT CLAIM NOTICE

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act.

Humana ID Number

H –

PLEASE SIGN FORM:

Member Signature X_____ Date ____/____/____

NOTE: If this form is signed by anyone other than the member, additional documentation is required authorizing that representative. This may include an Appointment of Representative (AOR) form or statement, a Power of Attorney (POA), or other legal documentation. An AOR form is available at https://www.humana.com/medicare-support/tools/member-forms for your convenience.

Humana is a Medicare Advantage HMO, PPO and PFFS organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

Please note that your reimbursement amount may vary. This will depend on the difference between the amount you paid at the pharmacy, and Humana's plan allowance **or** the rate negotiated with the pharmacy for that drug. Please be aware this means you might not receive the full amount back. If the amount you paid to the pharmacy is higher than the plan allowance, then the reimbursement will be less than what you actually paid for the drug. For more information, you can review Humana's full DMR policy in the Pharmacy coverage policies section of www.humana.com/pharmacy/medicare/tools/druglist.

Humana ID Number

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Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-800-457-4708 or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 - 4618

If you need help filing a grievance, call 1-800-457-4708 or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the 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
1-800–368–1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-457-4708 **(TTY: 711).**

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-457-4708 **(TTY: 711).**

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-457-4708 **(TTY: 711)**。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-457-4708 **(TTY: 711).**

한국어 (Korean): 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-457-4708 **(TTY: 711)** 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-457-4708 **(TTY: 711).**

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-457-4708 **(телетайп: 711).**

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-457-4708 **(TTY: 711).**

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-457-4708 **(ATS : 711).**

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-457-4708 **(TTY: 711).**

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-457-4708 **(TTY: 711).**

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-457-4708 **(TTY: 711).**

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-457-4708 **(TTY: 711).**

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-457-4708 **(TTY：711)** まで、お電話にてご連絡ください。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-457-4708 **(TTY: 711)** تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-457-4708 **(TTY: 711).**

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (هاتف الصُم: 711).