Medicare Advantage Part D
Direct Member Reimbursement Claim Form

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Please use this form to request reimbursement for covered Part D prescription drugs that were paid out of pocket. To receive timely reimbursement, please be sure fill out this form completely and submit it with any necessary documentation.

MEMBER INFORMATION

Member ID (see ID card):	Health plan name:	
Group/Employer name:	Health plan state:	
Last name :	First name:	Middle initial:
Mailing street address:		Apt.#
City:	State:	ZIP:
Date of Birth: / /		

PHYSICIAN AND PHARMACY INFORMATION

Prescribing physician name:	Pharmacy name:
Prescribing physician phone number with area code:	Pharmacy phone number with area code:

REASON FOR REQUEST (Select appropriate options for your request)

This claim form can be used to request reimbursement of covered expenses. You may select one of the reasons below to tell us more about your request. Note that the use of a claim form, such as this Enrollee Prescription Drug Claim Form, is not required to receive a reimbursement.

Filled not using a prescription ID card: ☐ Yes ☐ No		Filled at a non-network pharmacy: ☐ Yes ☐ No	
Covered under another health plan: ☐ Yes ☐ No		Illness while traveling outside of service area ☐ Yes ☐ No	
If yes, is this other plan Primary: ☐ Yes ☐ No		Network pharmacy/mail order pharmacy within reasonable driving distance could not fill in a timely manner ☐ Yes ☐ No	
If primary, include the explanation of benefits (EOB), primary health plan name: _____		While a patient at a health care facility (emergency dept., provider clinic, outpatient surgery) ☐ Yes ☐ No	
See section C on back of form - Coordination of Benefits.		Due to federal or state emergency/natural disaster ☐ Yes ☐ No	
My pharmacy billed the wrong plan ☐ Yes ☐ No			
A compound prescription (Pharmacist must fill out Section B on back of form) ☐ Yes ☐ No			
Retroactively enrolled with the plan ☐ Yes ☐ No			
Filled while waiting for drug approval ☐ Yes ☐ No			

ACKNOWLEDGEMENT

I certify that the patient for whom this claim is made is covered in this prescription drug program and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

Member or authorized representative signature: _____ Date: ____/____/____

Note: If form is completed and signed by an Authorized Representative rather than the member, an Authorization of Representation (AOR) must accompany the request or Power of Attorney (POA) must be on file with the plan.

INSTRUCTIONS FOR SUBMITTING FORM

1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in Section A (below). If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
2. Read the Acknowledgement (section 4) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
3. Send completed form with pharmacy receipt(s) to: Optum Rx Claims Department, PO Box 650287, Dallas, TX 75265-0287.
4. Do not submit a reimbursement request if:
   - Your prescription claim has already been paid by the plan.
   - Your Part D plan copays or costs applied to your deductible.
   - You have been told the claim processed in the coverage gap.

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

SECTION A - PHARMACY RECEIPTS FOR REIMBURSEMENT

Use the following checklist to ensure your receipts have all information required for your reimbursement request:

☐ Date Prescription Filled	☐ Name of drug and strength
☐ Name and address of pharmacy	☐ Prescription number (Rx number)
☐ Prescribing physician name or ID number	☐ Quantity
☐ National Drug Code (NDC) number	

SECTION B- PHARMACY INFORMATION (FOR COMPOUND PRESCRIPTIONS ONLY)

(Pharmacist must complete and sign)

- List VALID 11 digit NOC number (highest to lowest cost) in the box at right. Include EACH ingredient used in the compound prescription.
- For each NOC number, indicate the metric quantity expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL amount paid by the patient.
- Receipt(s) must be provided with this claim form.

*Individual quantities must equal the total quantity.
†Individual ingredient costs plus compounding fees must be equal to the total ingredient costs.

Date Filled: / /		Days Supply:	
VALID 11digit NDC#		Quantity*	Ingredient Cost'
Compounding Fee:			
Total:			

Signature of Pharmacist: X _____

SECTION C - COORDINATION OF BENEFITS

Sometimes you can have both Medicare and another insurance plan. They work together to pay claims for the same person. That process is called coordination of benefits. Insurance companies coordinate benefits to:
-Avoid duplicate payments by making sure the two plans don't pay more than the total amount of the claim.
You must submit claims within one year of date of purchase or as required by your plan.

When submitting an Explanation of Benefits (EOB) from another health plan or Medicare: If you have not already done so, submit the claim to the primary plan or Medicare. Once you receive the EOB, complete this form, submit the pharmacy receipts, and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the primary plan or Medicare.

When submitting a copay receipt: If your primary plan requires you to pay a copayment or coinsurance to the pharmacy, then no EOB is needed. Just complete this form and submit the pharmacy receipts showing the amount you paid at the pharmacy. These receipts will serve as the EOB.