Prescription Drug Claim Form

Please use this form when you paid for a Medicare Part D covered prescription drug and are asking us to pay you back. Check your Member Handbook for more details on completing this form.

☐ If you wish to have another person complete this form on your behalf, please check this box and return a signed ***Appointment of Representative Form (AOR)*** - Form CMS-1696 along with this claim form. The **AOR** form attached below, is also located on your plan's website or the Centers for Medicare & Medicaid Services (CMS) website.

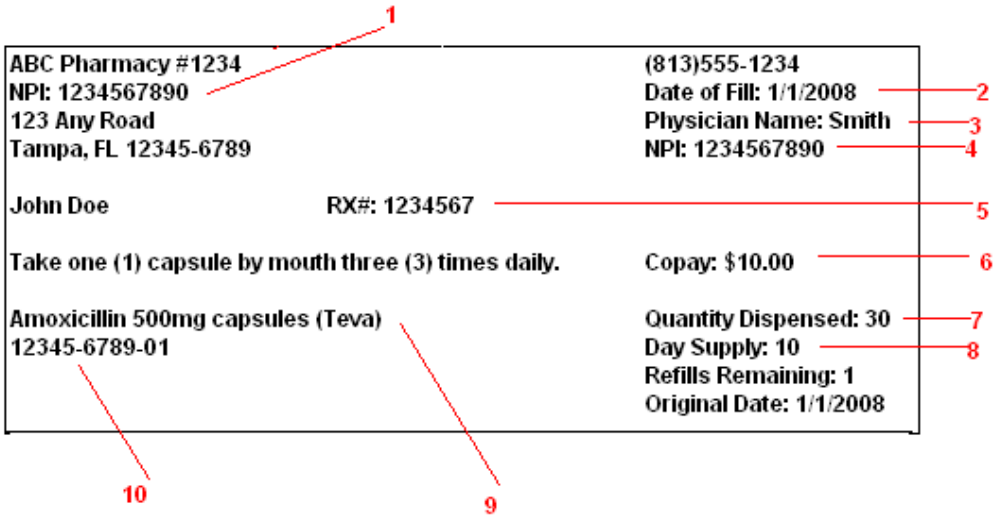
MEMBER INFORMATION

First Name:	Last Name:	Member ID Number:
Birth Date:	Address:	City
Phone Number:	State:	Zip Code:

INSTRUCTIONS

Complete this form for each claim and include the prescription label information and a proof of payment receipt. The claim MUST include the following information in your request. You can locate the information on your prescription label, or you may ask your pharmacy to help.

1. Pharmacy NPI (National Provider ID)
2. Date of Fill
3. Physician Name
4. Physician NPI (National Provider ID)
5. Prescription (RX) Number
6. Amount Paid
7. Quantity Dispensed
8. Day Supply
9. Drug Name
10. National Drug Code



REASON FOR REQUEST

☐ Received drug during hospital stay
☐ No Member ID card available
☐ Out-of-Network pharmacy used
☐ Emergency, please describe below
☐ Copayment error
☐ Pharmacy unable to process claim on-line
☐ Vaccine
☐ Other, please describe below

Coordination of Benefits – Other Insurance

- Are these drugs being taken for an on-the-job injury? ☐ Yes ☐ No
- Are these drugs covered under any other insurance? ☐ Yes ☐ No
- If yes, is other coverage: ☐ Primary ☐ Secondary

If <u>other</u> coverage is Primary, please attach a copy of your Explanation of Benefits (EOB).

Name of other insurance company:	Other insurance policy number:
Name of other insurance policyholder:	Name of policyholder's employer:

MAIL COMPLETED FORM TO:

Medicare Part D Pharmacy Claims
Attn: Member Reimbursement Department
PO Box 31577
Tampa, FL 33631-3577

Please note: Forms that are missing information, are not legible, or if the bill is not yet paid, may result in a delay or denial. A repayment of the amount you paid is not guaranteed.

I certify that the above information is correct.

x _____ _____

Member or Appointed Representative Signature | Date

Requested Prescription Drug Information

You may use the following space to list all covered prescription drugs you paid for and would like us to pay you back. Only the drugs listed in this section will be considered. Please clearly mark the information into each box.

Drug Name:	Physician Name:	Physician NPI:	Pharmacy NPI:	RX Number:
National Drug Code:	Date of Fill:	Quantity:	Day Supply:	Amount Paid:

Drug Name:	Physician Name:	Physician NPI:	Pharmacy NPI:	RX Number:
National Drug Code:	Date of Fill:	Quantity:	Day Supply:	Amount Paid:

Drug Name:	Physician Name:	Physician NPI:	Pharmacy NPI:	RX Number:
National Drug Code:	Date of Fill:	Quantity:	Day Supply:	Amount Paid:

Drug Name:	Physician Name:	Physician NPI:	Pharmacy NPI:	RX Number:
National Drug Code:	Date of Fill:	Quantity:	Day Supply:	Amount Paid:

Drug Name:	Physician Name:	Physician NPI:	Pharmacy NPI:	RX Number:
National Drug Code:	Date of Fill:	Quantity:	Day Supply:	Amount Paid:

Drug Name:	Physician Name:	Physician NPI:	Pharmacy NPI:	RX Number:
National Drug Code:	Date of Fill:	Quantity:	Day Supply:	Amount Paid:

Form CMS-1696 Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint the individual named in Section 2 to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 2: Acceptance of Appointment

To be completed by the representative:

I, , hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

INSTRUCTIONS AND REGULATION REQUIREMENTS

Instructions

Name of Party (required): This is the name of the person or entity which has standing to file a claim or appeal (the name of the person who has Medicare, or the name of the provider or supplier).

Medicare Number or National Provider Identifier (required): This must be completed when the person or entity appointing a representative has a Medicare number or National Provider Identifier. If not applicable, fill in, "not applicable".

All fields in Sections 1 and 2 are required unless noted as optional within the field. See the regulation at 42 CFR 405.910.

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. The form, OMHA-118, may be found at: https://www.hhs.gov/sites/default/files/OMHA-118.pdf

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227, TTY users call 1-877-486-2048), or your Medicare plan.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.