Coordination of Benefits / Direct Claim Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

MemberHealth®

Member/Subscriber Information See your prescription drug ID card.

Group No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last)

Street Address

City State ZIP

Date of Birth ☐☐ ☐☐ ☐☐☐☐
M M D D Y Y Y Y

Pharmacy Information

Name of Pharmacy

Street Address

City State ZIP

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

National Provider ID Number: _____

Request for a TrOOP Update

True out-of-pocket (TrOOP) Update: We would like to know if you have other coverage from one of these payers [please check only one and complete the Other Coverage Section on the back page]. Please include all pharmacy receipts and/or Explanation of Benefits when requesting a manual TrOOP update (see Other Coverage Section on back).

- ☐ A discount card
- ☐ A Patient Assistance Program (PAP)
- ☐ A secondary payer
- ☐ Other

Does this claim qualify for coverage?

You may submit a claim for Part D–covered medication dispensed by a nonparticipating pharmacy only for the reasons listed below. Please check the box that applies to your situation:

- ☐ **A.** I traveled outside my plan's service area and ran out of (or lost) my medication/ I became ill and could not access a network pharmacy.
- ☐ **B.** I was unable to obtain my medication in a timely manner within my service area (there was no network pharmacy within a reasonable driving distance that provides 24/7 service).
- ☐ **C.** My medication is not stocked regularly at an accessible network or mail-order pharmacy.
- ☐ **D.** My medication was dispensed from an emergency department, provider-based clinic, outpatient surgery facility, or other outpatient setting.
- ☐ **E.** I received a vaccine at my doctor's office. (Be sure to include the receipt from the physician and complete PHARMACY INFORMATION section on back.)
- ☐ **F.** I was evacuated or displaced from my residence due to a State- or Federally declared disaster or health emergency.

Coordination of Benefits

(Another Health Plan has paid a portion) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?

- ☐ Yes ☐ No
- ☐ Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid
- ☐ Card Program

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X _____
Signature of Member

Other Coverage Section: (complete the information below if the patient has other **prescription drug coverage programs**)

Other Insurance Company Name

Other Policy Number

Other Policy Holder Name

Date of Service	Drug Name – Rx Number	Charge	Amount Patient Paid	Amount Other Payer Paid

PHARMACY INFORMATION (For Compound and Vaccine Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- For vaccines, make sure the physician's office includes the drug quantity, days supply, NDC#, and the charge (do not include the administration fee).

RX#		**Date Filled**		**Days Supply**	

VALID 11-digit NDC#	Quantity
Total Quantity	
Total Charge	

When To Use This Form

- Use this form to submit claims under Coordination of Benefit Rules.
- You must complete a **separate** claim form for **each pharmacy** used.
- You must submit claims no later than 3 months after the end of the benefit year for the date of purchase in accordance with the Centers for Medicare and Medicaid Services (CMS).

Other Coverage Paid

You must first submit the claim to the primary insurance carrier. Once the Explanation of Benefits (EOB) from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipt(s) on a blank sheet of paper, and enclose the EOB from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription Drug Programs or HMO Plans

Card Program: If the primary plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no EOB is needed. Just complete this form and tape the prescription receipt(s) on a blank sheet of paper that shows the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

Instructions

Read carefully before completing this form

1. **Receipts should contain the following information:**
   - Date prescription filled
   - DAW (Dispense As Written)
   - Name and address of pharmacy
   - Doctor name
   - NDC number (drug number)
   - Name of drug and strength
   - Quantity and days supply
   - Prescription number (Rx number)
   - Amount paid

   Your pharmacist can provide the necessary information if your claim or bill is not itemized.
2. The plan member should read the acknowledgment carefully, then sign and date this form.
3. Return the completed form and receipt(s) to:

   MemberHealth/Medco
   P.O. Box 14718
   Lexington, KY 40512

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.