



Medicare Part D Drug Claim Form

Please complete each section of this form.

Questions about completing this form? Call the customer service number on the back of your ID card:

8 a.m. – 8 p.m., local time, 7 days a week

Mail your completed claim form(s) and original, detailed pharmacy receipts to:

Experience Health Medicare

AdvantageSM (HMO)

PO Box 17509

Winston-Salem, NC 27116-7509

MEMBER INFORMATION

First name			
Last name			
Date of birth	__ / __ / ____		
Identification #	_____		
Street address	_____		
City	_____		
State		Zip	

Your identification (ID) number is listed on your member ID card.

PHARMACY INFORMATION

Name	_____		
Street address	_____		
City	State	Zip	

OTHER HEALTH INSURANCE INFORMATION

If you have other pharmacy benefit insurance (i.e., auto) that covers this drug, please send copies of:

1. Both sides of your other health insurance card
2. The Explanation of Benefits (EOB) page that shows the amount paid, or the reason why coverage was denied.

WHY ARE YOU SENDING THIS CLAIM?

Please check any of the reasons shown below, or write your own reason.

- I became sick or ran out of my medicine while traveling outside of my plan's service area (but still within the U.S.).
- I couldn't get a covered drug when I needed it because I couldn't find a 24-hour network pharmacy near me.
- The covered drug I needed is not usually stocked at a network retail (local) or home delivery pharmacy service.
- I couldn't use a network pharmacy because I was evacuated or displaced due to a federally-declared disaster or health emergency.
- I couldn't choose a network pharmacy because I received the covered drug while in an ER department, medical clinic, or other outpatient setting (i.e., same-day surgery).
- Other (explain)

INSTRUCTIONS FOR COMPLETING THIS FORM

- Part D payment rules say that your doctor must:
 - Have a valid 10-digit National Provider Identifier (NPI) number, *and*
 - Accept Medicare claims, *or*
 - Have filed forms to show he or she has asked for Medicare's approval to write prescriptions.
- Use one claim form for each member and each pharmacy.
(i.e., one member + two pharmacies = two forms. If two members each use two pharmacies = four forms)
- If you need more claim forms, visit experiencehealthnc.com or call the member service number shown on your ID card.
- Do not use this form to submit charges for durable medical equipment (i.e., blood glucose meter or test strips).
- Original, detailed pharmacy receipts are required. Not accepted: canceled checks or receipts that only show the amount paid.
- Before you send in your claim(s), be sure to make a copy of all forms and receipts.

DRUG CLAIM INFORMATION

Original pharmacy receipts are required. Please do not staple them to this form. Receipts must show:

- | | | | | |
|----------------------------------------|-----------------------------------------|------------------------------------|---------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Pharmacy name | <input type="checkbox"/> Drug name | <input type="checkbox"/> Quantity | <input type="checkbox"/> NDC number | <input type="checkbox"/> NPI number |
| <input type="checkbox"/> Strength | <input type="checkbox"/> Date purchased | <input type="checkbox"/> Drug cost | <input type="checkbox"/> Days' supply | <input type="checkbox"/> Prescription number |

All the fields below must be completed in order to process your claim. If you need help finding the information, please ask your pharmacist.

CLAIM FORM

Example form

Rx number	0 0 0 0 0 6 0 1 1 4 8 1			<p>Your pharmacist can give you the national drug code (NDC) and your doctor's national provider identifier (NPI) numbers.</p> <p>National Drug Code</p> <p>National Provider Identifier</p>
Date filled	1 0 / 0 1 / 2 0 1 6			
Quantity	60	Days' supply	30	
Drug name	Name of Drug			
NDC number	0 0 1 8 6 5 0 2 2 2 8			
NPI number	9 2 1 5 2 4 1 1 6 3			
Total cost of drug	\$146.04	Amount you paid	\$36.57	

Claim 1

Rx number	_____			<p>Your pharmacist can give you the national drug code (NDC) and your doctor's national provider identifier (NPI) numbers.</p> <p>National Drug Code</p> <p>National Provider Identifier</p>
Date filled	___ / ___ / ___			
Quantity	_____	Days' supply	_____	
Drug name	_____			
NDC number	_____			
NPI number	_____			
Total cost of drug	_____	Amount you paid	_____	

Claim 2

Rx number	_____	<i>Your pharmacist can give you the national drug code (NDC) and your doctor's national provider identifier (NPI) numbers.</i> National Drug Code National Provider Identifier
Date filled	___/___/___	
Quantity	_____ Days' supply	
Drug name	_____	
NDC number	_____	
NPI number	_____	
Total cost of drug	_____ Amount you paid	

COMPOUND DRUG INFORMATION

A compound drug is made of two or more drugs that are combined. If you are taking a compound drug, your pharmacist needs to enter the NDC numbers for all the ingredients used.

NDC number	Drug ingredient	Quantity	Cost

MEMBER CERTIFICATION

Your signature below certifies that:

- The information on this form is correct
- The member named above is eligible for pharmacy benefits
- The member named above received the drug(s) listed
- These benefits have not been assigned; any further assignment is void
- I give my permission to share the details of this form with Prime Therapeutics LLC

Member or legal representative signature _____

Date _____

OTHER RESOURCES



1-800-MEDICARE (1-800-633-4227)

TTY/TDD: 1-877-486-2048

Calls answered 24 hours/day,
7 days/week, except on federal holidays.



Health Care Insurance Fraud Hotline:

1-800-731-3269

TTY/TDD 1-888-967-7463

Monday through Friday, 8 a.m. to 5 p.m. CT.

It is a crime to knowingly give false information or submit a fraudulent claim to get paid for a benefit. It is a crime to give false information on an insurance application. If convicted, the person may have to do any or all of the following: pay the money back, pay a fine, and/or serve time in prison.

Fraud increases the cost of health care for all of us. If you know of (or suspect) any type of health insurance fraud, please call one of the hotline numbers listed above. You don't need to give your name; all calls are confidential.

DISCLAIMER

Experience Health is an HMO plan with a Medicare contract. Enrollment in Experience Health depends on contract renewal.

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Non-Discrimination and Accessibility Notice

Experience Health (EXH) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, contact:

Customer Service

Call the number on the back of your ID card

If you believe that Experience Health has 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:

Experience Health, P.O. Box 52382, Durham, NC

27717 Attention: Civil Rights Coordinator-Privacy,

Ethics & Corporate Policy Office

Call: 833-777-7394 (TTY, 711)

Fax: 919-287-5613

E-mail: civilrightscoordinator@experiencehealthnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office is available to help you. 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:

Online: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf> Mail:

U.S. Department of Health & Human Services

200 Independence Avenue, SW Room 509F

HHH Building Washington, D.C., 20201

Call: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available online at:

<http://www.hhs.gov/civil-rights/filing-a-complaint/index.html>

This notice and/or attachments may have important information about your application or coverage through Experience Health. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Contact:

Customer Service

Call the number on the back of your ID card

Discrimination is Against the Law

Experience Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Experience Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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Multi-language Interpreter Services

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Services number on the back of your member ID card.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número que figura al dorso de su tarjeta de identificación.

注意：如果您講廣東話或普通話，您可以免費獲得語言援助服務。請撥打您會員 ID 卡背面的客服部電話號碼。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng trên mặt sau thẻ thành viên ID của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 가입자 ID 카드 뒷면에 있는 고객센터 전화번호로 전화해 주십시오

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Téléphonnez le Service clients au numéro qui figure au dos de votre carte de membre.

ملحوظة: إذا كنت تتحدث اللغة العربية فإن خدمات المساعدة اللغوية متوفرة لك بالملجأ. اتصل برؤم خدمة العملاء اموضح عمل ظهر بطاقة هوية العضو الخاصة بك.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau tus nab npawb xovtoo ntawm Lub Chaw Pab Cuam Tswv Cuab uas nyob sab tom qab koj daim npav tswv cuab ID.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Позвоните в Отдел обслуживания по номеру, указанному на оборотной стороне вашей карточки участника

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero ng Serbisyo sa Kostumer sa likod ng Id kard ng miyembro.

સુચના: જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિ:શુલ્ક ઉપલબ્ધ છે. તમારા સભ્યપદ ઓળખપત્રની (આઈ.ડી) પાછળની બાજુ પર આપેલ ગ્રાહક સેવાઓના નંબર પર કોલ કરો

ចំណាំ: ប្រសិនបើ លើកស្ទួយសេវាសម្រាប់អ្នកនិយាយភាសាខ្មែរ
បន្តទៀតសេវាសម្រាប់អ្នកនិយាយភាសាខ្មែរ ឬសេវាសម្រាប់អ្នកនិយាយភាសាខ្មែរ
សម្រាប់អ្នកនិយាយភាសាខ្មែរ ឬសេវាសម្រាប់អ្នកនិយាយភាសាខ្មែរ ឬសេវាសម្រាប់អ្នកនិយាយភាសាខ្មែរ

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie die Nummer des Kundenservice an, die auf der Rückseite Ihrer Mitglieds-ID-Karte angegeben ist.

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। अपने सदस्य आईडी कार्ड के पीछे मौजूद ग्राहक सेवाएं नंबर पर कॉल करें।

ឡើងទុក: ពុំទាំងអស់ទេវាសាខា, អ្នកប្រើប្រាស់ទាំងអស់ទេវាសាខាដែលបានប្រើប្រាស់. តើតើមានទេវាសាខាណាមួយដែលបានប្រើប្រាស់ ឬទេវាសាខាណាមួយដែលបានប្រើប្រាស់.

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。メンバーIDカードの裏面のカスタマーサービス番号にお電話ください。

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