



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.
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.
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 or Fax to: 866-754-5362
P.O. Box 14140
Lexington, KY 40512-4140

PART 1: MEMBER INFORMATION

Humana ID Number (required)

Form for Humana ID Number with a grid containing 'H' and other digits.

Medicare ID Number

Form for Medicare ID Number with a grid of 10 boxes.

Member Last Name

Form for Member Last Name with a grid of 20 boxes.

Member First Name

Form for Member First Name with a grid of 20 boxes.

M.I.

Form for Member Middle Initial with a grid of 2 boxes.

Street Address

Form for Street Address with a grid of 30 boxes.

City

Form for City with a grid of 20 boxes.

State

Form for State with a grid of 2 boxes.

Zip Code

Form for Zip Code with a grid of 5 boxes.

Member Phone Number

Form for Member Phone Number with a grid of 12 boxes.

Patient Residence:

- Home
Nursing Home
Assisted Living
Group Home
Intermediate Care
Hospice

Date of Birth (mm/dd/yyyy)

Form for Date of Birth with a grid of 8 boxes.

Gender

Form for Gender with Male and Female options.

Person Completing This Form

Form for Person Completing This Form with Member, Spouse, Child, and Other options.

PART 2: RECEIPT INFORMATION

Ensure your receipt includes the following information:

- Date Filled, Medication Strength (Dose), Quantity, Day(s) Supply, National Drug Code (NDC), RX Number, Dosage Form, Physician Name, RX Price, Medication Name, Physician ID, Vaccine Administration fee, and compound ingredients.

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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

- |  |   |
|--|---|
| <input type="checkbox"/> Pharmacy will not accept my Humana plan<br><input type="checkbox"/> Pharmacy was unable to process my claim electronically<br><input type="checkbox"/> I did not have my plan information at the time of purchase<br><input type="checkbox"/> I was charged for medications received during an Emergency Room visit | <input type="checkbox"/> I believe the claim was paid incorrectly<br><input type="checkbox"/> I was administered a Part D covered vaccine in my doctor's office<br><input type="checkbox"/> I filled my medication during an emergency<br><input type="checkbox"/> 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:

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### 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.

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**MEDICARE PRESCRIPTION DRUG CLAIM FORM  
FOR MEMBER REIMBURSEMENT**

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**PLEASE SIGN FORM:**

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**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.

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](http://www.humana.com/pharmacy/medicare/tools/druglist).

## Important!

### At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:  
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618  
If you need help filing a grievance, call the number on your ID card 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, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

### Auxiliary aids and services, free of charge, are available to you.

#### Call the number on your ID card (TTY: 711)

Humana provides 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.

### Language assistance services, free of charge, are available to you.

#### Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación (TTY: 711)... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 (TTY: 711)... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị (TTY: 711)... 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. ID 카드에 적혀 있는 번호로 전화해 주십시오 (TTY: 711)... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card (TTY: 711)... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении (телетайп: 711)... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou (TTY: 711)... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre (ATS: 711)... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej (TTY: 711)... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação (TTY: 711)... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa (TTY: 711)... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet (TTY: 711)... 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。お手持ちのIDカードに記載されている電話番号までご連絡ください (TTY: 711)...

توجه: اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید (TTY: 711)...

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jii'k'eh, éí ná hólq, námbuu ninaaltsoos yézhí, bee néé ho'dółzin bikáá'ígíí bee hólne' (TTY: 711)...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك (TTY: 711).