

Section 1: Member Information

Section 1 Instructions:

1. Complete this section fully and submit this request within the filing period which is **365 days from the date the prescription is filled.** For questions about the filing period, please call the number on the back of your member ID card;
2. If submitting a request where medications were obtained from multiple pharmacies or physicians or a request is for multiple members, please submit a separate form for each pharmacy or physician and member.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Member ID Number (required): | | | | |
| Member Name (Last, First, MI): | | | Date of Birth (mm/dd/yyyy): | |
| Street Address: | | | Phone Number: | |
| City: | | State: | | Zip Code: |
| Gender: | Person Completing Form:  Member  Spouse Child  Other: | | | |
| Patient Residence:  Home  Nursing Home Assisted Living Immediate Care Hospice | | | | |

Is the member eligible for primary prescription drug coverage

from another insurance provider?  N Y

*If yes:* Was the claim submitted to the other insurance provider? N Y Did the other insurance provider pay as the primary insurer? N Y



Name of other insurance provider: Member ID:

Section 2: Pharmacy and Provider Information

Section 2 Instructions:

1. Provide the requested information about the pharmacy where medications were received AND the doctor that prescribed them;
2. Your pharmacy and doctor will be able to assist you if you are missing any of this information.

## Pharmacy Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pharmacy Name: | | Pharmacy NCPDP or NPI: | | |
| Street Address: | | | Phone Number: | |
| City: | State: | | | Zip Code: |
| Pharmacy Service Type: Retail Compounding Home Infusion Institutional Long-term Care Manage Care Organization Mail Order Specialty | | | | |

**Physician Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Physician Name: | | Physician NCPDP or NPI: | | | Physician Tax ID: |
| Street Address: | | | Phone Number: | | |
| City: | State: | | | Zip Code: | |

Section 3: Prescription Drug Information

Section 3 Instructions:

1. Fill out the space below completely for **EACH** requested medication. If any information is missing, we will be unable to process your request. Your pharmacy can provide any information you are missing;
2. Include pharmacy receipt(s) **AND** proof of payment. Tape receipts to a separate page and submit with claim form. If medication was given in the emergency room or doctor’s office include detailed statement.

*Note: Services incurred outside the United States are not payable under Medicare plans.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is this a compound medication? No Yes  *If yes, please attach compound form from pharmacy if available* | | | | | |
| Was this prescription filled outside the US?  No  Yes | | | | | |
| Is this a vaccine? *If yes:*  No  Yes Vaccine Cost: $ Admin Fee: $ | | | | | |
| National Drug Code (NDC) | | Drug Name: | | Total Cost:  $ | |
| Fill Date (mm/dd/yyyy): | Rx Number: | | Qty: | | Day Supply: |
| Dosage Form | Strength: | | Dispense as Written Code (if applicable): | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is this a compound medication? No Yes  *If yes, please attach compound form from pharmacy if available* | | | | | |
| Was this prescription filled outside the US?  No Yes | | | | | |
| Is this a vaccine? *If yes:*  No Yes Vaccine Cost: $ Admin Fee: $ | | | | | |
| National Drug Code (NDC) | | Drug Name: | | Total Cost:  $ | |
| Fill Date (mm/dd/yyyy): | Rx Number: | | Qty: | | Day Supply: |
| Dosage Form | Strength: | | Dispense as Written Code (if applicable): | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is this a compound medication? No Yes  *If yes, please attach compound form from pharmacy if available* | | | | | |
| Was this prescription filled outside the US?  No Yes | | | | | |
| Is this a vaccine? *If yes:*  No  Yes Vaccine Cost: $ Admin Fee: $ | | | | | |
| National Drug Code (NDC) | | Drug Name: | | Total Cost:  $ | |
| Fill Date (mm/dd/yyyy): | Rx Number: | | Qty: | | Day Supply: |
| Dosage Form | Strength: | | Dispense as Written Code (if applicable): | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is this a compound medication? No Yes  *If yes, please attach compound form from pharmacy if available* | | | | | |
| Was this prescription filled outside the US?  No Yes | | | | | |
| Is this a vaccine? *If yes:*  No Yes Vaccine Cost: $ Admin Fee: $ | | | | | |
| National Drug Code (NDC) | | Drug Name: | | Total Cost:  $ | |
| Fill Date (mm/dd/yyyy): | Rx Number: | | Qty: | | Day Supply: |
| Dosage Form | Strength: | | Dispense as Written Code (if applicable): | | |

*[If additional space is needed, you may access a blank drug information form from our website at:* [**https://www.humana.com/pharmacy/prescription**](http://www.humana.com/pharmacy/prescription-coverages/medicare-claim-forms)**-c**[**overages/medicare**](http://www.humana.com/pharmacy/prescription-coverages/medicare-claim-forms)**-claim**[**-forms**](http://www.humana.com/pharmacy/prescription-coverages/medicare-claim-forms) ]

Section 4: Reason for Request

Pharmacy will not accept my Humana Plan I did not have my plan information at the time of purchase

I was charged for medications receive during and ER visit

I believe the claim was paid incorrectly

I received a medication while on a cruise **(Cruise itinerary must be included with request)**

I received a Part D covered vaccine in my doctor’s office

I filled my medication during a natural disaster or state of emergency

Other:

Please further explain the issue:

Section 5: Sign and Return

**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/member/documents**](http://www.humana.com/member/documents-and-forms)**-and-f**[**orms**](http://www.humana.com/member/documents-and-forms) for your convenience.

Member Signature: Date:

Return the completed **form** and **receipt(s)**:

**Mail**: Humana Pharmacy Solutions

P.O. Box 14140 Lexington, KY 40512-4140

**Fax**: 1-866-754-5362

State Fraud Warning Statements

Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution of fraud. By providing these notices, neither Humana nor its subsidiaries imply that they are authorized to write insurance in all 50 states.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Alaska:** A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

**Arizona:** For your protection, Arizona law requires the following statement to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties. The authorization shall remain in effect for the term of your coverage. You or your designated representative is entitled to receive a copy of this claim form.

**Arkansas:** Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Delaware:** Any Person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Hawaii:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

**Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Kansas:** Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be subject to prosecution for fraud and guilty of insurance fraud as determined by a court of law.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines.

**Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraudagainst an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon:** 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, may have committed a fraudulent insurance act.

**Pennsylvania:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Utah:** Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**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, gender identity, ancestry, ethnicity, marital status, religion, or language. 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 **877-320-1235** 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 their Complaint Portal, available at **https://ocrportal.hhs.gov/ ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at [**https://www.hhs.gov/ocr/office/file/index.html**](http://www.hhs.gov/ocr/office/file/index.html).

* **California residents**: You may also call California Department of Insurance toll-free hotline number:

**800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (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. 877-320-1235 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

**繁體中文 :** 撥打上面的電話號碼即可獲得免費語言援助服務。

**(Chinese)**

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**한국어 :** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

**(Korean)**

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis. **Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d’aide linguistique. **Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer. **Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.

**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti. **Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

برای دریافت تسهیالت زبانی بصورت رایگان با شماره فوق تماس بگیرید. **(Farsi) فارسی** saad jiik’eh t’11 bee 47 h0d77lnih bich’9’ wolta’7g77 bee hani’7 bee b44sh W0dah7 **ЁNavajoЂ: Bizaad Diné** nik1’adoowo[. 1k1’1n7da’1wo’d66 bee

الرجاء االتصال بالرقم المبين أعاله للحصول على خدمات مجانية للمساعدة بلغتك **(Arabic) العر بية**

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