

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 receipt (s) within the filing period specified by your Humana plan. **You will have 12 months from the date the prescription is filled to submit your claim.** For questions about your filing period, please call the number on the back of your member ID card.

Note: Services performed outside the United States are not payable under the Medicaid plan.

3. Please submit a separate form for each family member and pharmacy from which you paid for your medications.

Part 2: Receipt Information

1. Include all pharmacy receipt(s) AND **proof of payment.** Tape receipt (s) to a separate page and submit with claim form. If medication was given in Emergency Room or Doctor's office include detailed statement.
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

1. 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 attached receipts.

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 (claim cannot be processed without this)				Date of Birth (mm/dd/yyyy)				Patient Residence: <input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Group Home <input type="checkbox"/> Intermediate Care <input type="checkbox"/> Hospice
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Member Last Name				First Name			MI	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Gender		Relationship						
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Member Street Address								
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
City				State	ZIP Code	Member Telephone		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

PART 2: RECEIPT INFORMATION

Ensure your receipt includes the following information:

- | | |
|---|--|
| <input type="checkbox"/> Date Filled | <input type="checkbox"/> Quantity |
| <input type="checkbox"/> Medication Name | <input type="checkbox"/> Day (s) Supply |
| <input type="checkbox"/> Rx Number | <input type="checkbox"/> Rx Price (amount you paid including tax) |
| <input type="checkbox"/> National Drug Code (NDC) | <input type="checkbox"/> Physician Name |
| <input type="checkbox"/> Medication Strength | <input type="checkbox"/> Physician ID (NPI or DEA#) |
| <input type="checkbox"/> Dosage Form | <input type="checkbox"/> If drug is a compound, list the NDCs for all ingredients and quantity of each |

DISPENSE AS WRITTEN (DAW):

- 0 - Not applicable
- 1- Doctor requires brand product be dispensed
- 2- Patient requires brand product be dispensed
- 5 - Brand submitted as generic
- 7-Brand mandated by state law

PART 3: PHARMACY INFORMATION

Pharmacy Name

Pharmacy ID (NABP or NPI#)

[Grid for Pharmacy Name]

[Grid for Pharmacy ID]

Pharmacy Street Address

[Grid for Pharmacy Street Address]

City

State

ZIP Code

Pharmacy Telephone

[Grid for City]

[Grid for State]

[Grid for ZIP Code]

[Grid for Pharmacy Telephone]

- Pharmacy Service Type: Retail Compounding Home Infusion Institutional

- Long Term Care Managed Care Organization Mail Order Specialty

Description of Issue:

- Pharmacy will not accept my Humana plan
- I believe the claim was paid incorrectly
- Pharmacy was unable to process my claim electronically
- I filled my medication during an emergency
- I did not have my plan information at the time of purchase
- I have drug coverage with a plan other than Humana (Coordination of Benefits)
- I was charged for medications received during an Emergency Room visit

Name of Ins Co _____
 Ins Co Phone# _____
 Employer Name _____
 Member ID _____

Please explain the issue:

[Four horizontal lines for explaining the issue]



Healthy Horizons™
in Florida

ENGLISH: This information is available for free in other languages and formats. Please contact our Customer Service number at **800-477-6931**. If you use **TTY**, call **711**, Monday – Friday, 8 a.m. to 8 p.m.

SPANISH: Esta información está disponible gratuitamente en otros idiomas y formatos. Comuníquese con nuestro Servicio al Cliente llamando al **800-477-6931**. Si usa un **TTY**, marque **711**. El horario de atención es de lunes a viernes de 8 a.m. a 8 p.m.

CREOLE: Enfòmasyon sa a disponib gratis nan lòt lang ak fòma. Tanpri kontakte nimewo Sèvis Kliyan nou an nan **800-477-6931**. Si ou itilize **TTY**, rele **711**, Lendi - Vandredi, 8 a.m. a 8 p.m.

FRENCH: Ces informations sont disponibles gratuitement dans d'autres langues et formats. N'hésitez pas à contacter notre service client au **800-477-6931**. Si vous utilisez un appareil de télétype (**TTY**), appelez le **711** du lundi au vendredi, de 8h00 à 20h00.

ITALIAN: Queste informazioni sono disponibili gratuitamente in altre lingue e formati. La preghiamo di contattare il servizio clienti al numero **800-477-6931**. Se utilizza una telescrivente (**TTY**), chiami il numero **711** dal lunedì al venerdì tra le 8 e le 20:00.

RUSSIAN: Данную информацию можно получить бесплатно на других языках и в форматах. Для этого обратитесь в отдел обслуживания клиентов по номеру **800-477-6931**. Если Вы пользователь **TTY**, звоните по номеру **711** с понедельника по пятницу, с 8.00 до 20.00.

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **800-477-6931 (TTY: 711)**. We are available Monday through Friday, from 8 a.m. to 8 p.m. Eastern time. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

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 **800-477-6931** 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>.

Auxiliary aids and services, free of charge, are available to you. **800-477-6931 (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.

Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **800-477-6931 (TTY: 711)**.

Español: (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **800-477-6931 (TTY: 711)**.

Kreyòl Ayisyen: (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **800-477-6931 (TTY: 711)**.

Tiếng Việt: (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **800-477-6931 (TTY: 711)**.