Humana
Healthy Horizons™ in Florida

Prescription Drug Claim Form for Member Reimbursement

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		

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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? ◯ No ◯ Yes	*If 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):	

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Was this prescription filled outside the US? ◯No ◯Yes			
Is this a vaccine? ◯No ◯Yes	*If 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-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 received during an 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: _____

_____

_____

_____

_____

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.

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-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

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

Call if you need us

If you have any questions, please call us at **1-800-477-6931** (**TTY: 711**). We're available **Monday – Friday, from 8 a.m. – 8 p.m. Eastern Time**. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit Humana.com for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

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'autre 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 Kreyòle 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)**.