Humana

HUMANA GOLD PLUS INTEGRATED (Medicare-Medicaid Plan)
PRESCRIPTION DRUG CLAIM FORM
FOR MEMBER REIMBURSEMENT

CLAIM FORM INSTRUCTIONS

Part 1: Member Information

1. Complete all information under Part 1. Your Humana Medicare-Medicaid 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.** For questions about your filing period, please call the number on the back of your member ID card.
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. If medication was given in Emergency Room or Doctors office include detailed statement. Note: Services incurred outside the United States are not payable under Medicare/Medicaid plan.
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 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**
P.O. Box 14140
Lexington, KY 40512-4140

or Fax to: **866-754-5362**

PART 1: MEMBER INFORMATION

Humana ID Number (claim cannot be processed without this) _____ – __

Date of Birth (mm/dd/yyyy) __ – __ – ____

Patient Residence:
- ☐ Home
- ☐ Nursing Home
- ☐ Assisted Living
- ☐ Group Home

Member Last Name _____ Member First Name _____ M.I. _

Street Address _____

City _____ State __ Zip Code _____ Member Phone Number (___) ___ – ____

Gender ☐ Male ☐ Female

Person Completing This Form ☐ Member ☐ Spouse ☐ Child ☐ Other

PART 2: RECEIPT INFORMATION

Ensure your receipt includes the following information:

- ☐ Date Filled
- ☐ Medication Name
- ☐ RX Number
- ☐ Medication Strength
- ☐ Dosage Form
- ☐ Quantity
- ☐ RX Price (amount you paid including tax)
- ☐ Physician Name
- ☐ Physician ID (NPI or DEA #)

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

☐ Pharmacy will not accept my Humana plan

☐ Pharmacy was unable to process my claim electronically

☐ I did not have my plan information at the time of purchase

☐ I was charged for medications received during an Emergency Room visit

☐ I believe the claim was paid incorrectly

☐ I was administered a Part D covered vaccine in my doctor's office

☐ I filled my medication during an emergency

☐ 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:

_____

_____

_____

_____

_____

_____

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.

Humana ID Number –

PLEASE SIGN FORM:

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.

Humana Gold Plus Integrated H0336-001 (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees.

Call if you need us
If you have questions, you can call us at 1-800-787-3311 (TTY: 711). We're available Monday - Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **humana.com/medicare/medicaid-dual/illinois** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

You can get this document for free in Spanish, or speak with someone about this information in other languages for free. Call Customer Care at 1-800-787-3311 (TTY: 711). The call is free.

Puede obtener este documento gratis en español, hablar con alguien sobre esta información en otros idiomas gratuitamente. Llame al 1-800-787-3311. La llamada es gratuita.

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Customer Service at 1-800-787-3311 (TTY 711).

If you believe that Humana Inc. or its subsidiaries have 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:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 – 4618
1-800-787-3311, or if you use a TTY, call 711.

You can file a grievance by mail or phone. If you need help filing a grievance, Customer Service 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 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-787-3311 (TTY: 711).**

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-787-3311 (TTY: 711).**

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-787-3311 (TTY: 711).**

繁體中文 (Chinese): 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 **1-800-787-3311 (TTY: 711)**。

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-787-3311 (TTY: 711)** 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-787-3311 (TTY: 711).**

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-787-3311 (телетайп: 711).**

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-787-3311 (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 **1-800-787-3311 (TTY: 711).**

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-787-3311 (TTY: 711).**

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-787-3311 (ATS : 711).**

Ελληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-800-787-3311 (TTY: 711).**

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-787-3311 (TTY: 711).**

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih **1-800-787-3311 (TTY: 711).**

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-787-3311 (رقم هاتف الصم والبك: 711).**

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-787-3311 (TTY: 711)** पर कॉल करें।

وردُا (Urdu):

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-787-3311 (TTY: 711)** ۔