CarePlus HEALTH PLANS

PRESCRIPTION DRUG CLAIM FORM
FOR MEMBER REIMBURSEMENT

CLAIM FORM INSTRUCTIONS

Part 1: Member Information

- Complete all information under Part 1. Your CarePlus ID Number is on your member ID card.

Part 2: Receipt and Prescription Drug Information

- Include all original pharmacy receipts and patient package insert(s) if applicable. Cash register receipts are not sufficient. Tape receipt(s) and patient package insert(s) to a separate page and submit with claim form. If medication was provided in ER or doctor's office, provide itemized statement.
- Receipt(s) must contain the information outlined under Part 2 of the claim form below.

Part 3: Pharmacy Information

- Provide information about the pharmacy or doctor's office where medications were obtained.
- Please submit a separate form for each pharmacy from which you purchase medications.

Part 4: Description of Issue

- Provide information about the reason of your request.
  Note: Prescriptions that are filled by pharmacies outside the United States and its territories are not covered; e.g., cruise ships.

If your receipt(s) and insert(s) are missing any of the required information, please ask your pharmacy or doctor's office to provide it. Remember to keep a copy of the completed claim form and receipt(s) for your records.

If you have any questions, please call Member Services at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays, and we will return your call within one business day.

Once all sections have been filled in, please sign and date. Your signature attests that all information is accurately represented by the completed form and accompanying documents.

Mail the completed form, receipt(s), and patient package insert(s) to:

CarePlus Health Plans
Attention: Member Services Department
11430 NW 20th Street, Suite 300
Miami, FL 33172

PART 1: MEMBER INFORMATION

CarePlus ID Number _____

Date of Birth (mm/dd/yyyy) _____

Medicare ID Number _____

Member Last Name _____

First Name _____

MI _____

Gender

☐ Male ☐ Female

Person Completing This Form

☐ Member ☐ Spouse ☐ Child ☐ Other _____

Member Street Address _____

City _____

State _____

ZIP Code _____

Member Telephone _____

Patient Residence:	
☐	Home
☐	Nursing Home
☐	Assisted Living
☐	Group Home
☐	Intermediate Care
☐	Hospice

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PART 2: RECEIPT AND PRESCRIPTION DRUG INFORMATION

Ensure your receipt includes the following information:

- ☐ Date Filled
- ☐ Medication Name
- ☐ Medication Strength
- ☐ Quantity
- ☐ Days Supply
- ☐ Rx Price (including tax)
- ☐ Dosage Form
- ☐ Rx Number
- ☐ National Drug Code (NDC)*
- ☐ Physician Name
- ☐ Physician ID (NPI or DEA#)

**In case of compound(s), NDCs for every ingredient are listed.*

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.

DAW:
- ☐ 0 – Not Applicable
- ☐ 1 – Doctor mandates that brand product be dispensed
- ☐ 2 – Patient mandates that brand product be dispensed
- ☐ 5 – Brand submitted as generic
- ☐ 7 – Brand mandated by state law

Is this a compound medication? ☐ Yes ☐ No If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No If yes: Vaccine Cost: $___________ Admin Fee: $______________

National Drug Code (NDC) Drug Name ____________ Total Cost ____________ Fill Date (mm/dd/yyyy) ____________ Rx Number ____________

Dispense as Written Code (if applicable) ____________ Quantity ____________ Day Supply ____________ Dosage Form Strength ____________

Is this a compound medication? ☐ Yes ☐ No If yes, please attach compound form from pharmacy if available

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Dispense as Written Code (if applicable)	**Quantity**	**Day Supply**	**Dosage Form Strength**

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Dispense as Written Code (if applicable)	**Quantity**	**Day Supply**	**Dosage Form Strength**

PART 3: PHARMACY INFORMATION

Pharmacy Name

Pharmacy ID (NCPDP or NPI#)

Pharmacy Street Address

City

State

ZIP Code

Pharmacy Telephone

Pharmacy Service Type: ☐ Retail ☐ Compounding ☐ Home Infusion ☐ Institutional ☐ Mail Order ☐ Long Term Care ☐ Managed Care Organization ☐ Specialty ☐ Other

Physician Information

Physician Name

Physician NCPDP or NPI

Street Address

City

State

ZIP Code

Phone Number

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PART 4: DESCRIPTION OF ISSUE

- ☐ Pharmacy will not accept my CarePlus 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 received a medication while on a cruise (Cruise itinerary must be included with request)
- ☐ I was administered a Part D covered vaccine in my doctor's office
- ☐ I filled my medication during a natural disaster or state of emergency
- ☐ I have drug coverage with a plan in addition to CarePlus (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.

Member Signature _____ 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 **www.CarePlusHealthPlans.com/members/forms-tools-resources** for your convenience.

CarePlus Health Plans, Inc. complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities. Any inquiries regarding CarePlus' non-discrimination policies and/or to file a complaint, also known as a grievance, please contact Member Services at 1-800-794-5907 (TTY: 711).

Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.
Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.