LINET
LIMITED INCOME NET PROGRAM

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 **36 months from the date the prescription is filled.** For questions about the filing period, please call the LINET helpdesk at 1-800-783-1307 (TTY users dial 711);
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):	Medicare ID Number:	
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: $_____	
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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: Limited Income NET Program
P.O. Box 14310
Lexington, KY 40512-4140

Fax: 1-877-210-5592

Important!

It is important you are treated fairly.

Medicare's Limited Income NET Program does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Medicare's Limited Income NET Program complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by the Medicare's Limited Income NET Program, 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 **1-800-783-1307** 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, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-800-783-1307 (TTY: 711)

Medicare's Limited Income NET Program 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. 1-800-783-1307 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
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。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ nika'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220