

Coordination of Benefits / Direct Claim Form

See the back for instructions. Complete all information.
 An incomplete form may delay your reimbursement.

Member/Subscriber Information *See your prescription drug ID card.*

Group No.

Member ID

Member Name (First, Last) _____

Street Address _____

City State ZIP

Date of Birth
M M D D Y Y Y Y

Pharmacy Information

Name of Pharmacy _____

Street Address _____

City State ZIP

Telephone (include area code)

National Provider ID Number: _____

Request for a TrOOP Update

True out-of-pocket (TrOOP) Update: We would like to know if you have other coverage from one of these payors [please check only one and complete the "Other Coverage Section" on the back page]. Please include all pharmacy receipts and/or Explanation of Benefits when requesting a manual TrOOP update (see Other Coverage Section on back).

- A discount card
- A Patient Assistance Program (PAP)
- A secondary payor
- Other

Does this claim qualify for coverage?

You may submit a claim for Part D-covered medication dispensed by a nonparticipating pharmacy only for the reasons listed below. Please check the box that applies to your situation:

- A. I traveled outside my plan's service area and ran out of (or lost) my medication/ I became ill and could not access a network pharmacy.
- B. I was unable to obtain my medication in a timely manner within my service area (there was no network pharmacy within a reasonable driving distance that provides 24/7 service).
- C. My medication is not stocked regularly at an accessible network or mail-order pharmacy.
- D. My medication was dispensed from an emergency department, provider-based clinic, outpatient surgery facility, or other outpatient setting.
- E. I received a vaccine at my doctor's office. (Be sure to include the receipt from the physician and complete PHARMACY INFORMATION section on back.)
- F. I was evacuated or displaced from my residence due to a State- or Federally declared disaster or health emergency.

Coordination of Benefits

(Another Health Plan has paid a portion) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?

- Yes No
- Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid
- Card Program
- Medco By Mail/mail-order pharmacy

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X
 Signature of Member

