

Medicare Part D Prescription Claim Form

Follow instructions on reverse side.

DIV MHY

Please Print

Member Name (Last, First, MI)	Date of Birth	Member ID Number
<input type="checkbox"/> Check if new address Street _____ City _____ State _____ Zip Code _____ Daytime Telephone () _____		
♦ Is this medication covered under any other group insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the name of the insurance company and other employer: _____		

To avoid having to submit a paper claim form:

- Always have your card available at time of purchase
- Always use pharmacies within your network
- Use medication from your formulary list
- If problems are encountered at the pharmacy, call the number on the back of your card.

Please complete the areas below. Incomplete forms will be returned to the member.						
Rx Number	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Directions	Days Supply	Rx Price w/Tax
Medication Name, Form, Strength			DAW	M.D. DEA#	NDC Number (11 digits)	

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Medicare Part D Covered Vaccinations

Print Name of Physician: _____ Physician DEA# or NPI#: _____

Attach a receipt from your physician showing the vaccine name, price, date given, and NDC code (if available)

Internal Use Only

Vaccine:	Date of Service:
Submitted Amount:	NCPDP #: 7014444
Allowed Amount:	7016666
NDC #:	7018888

Compounds: Even if you have itemized receipts, the following must be completed by your pharmacist if the prescriptions being submitted for reimbursement are compound medications.

NDC Number	Ingredient	Quantity	Cost

Prescription Information

— IMPORTANT —

Number of receipts attached:

All prescription claims must have prescription receipts/labels which include:

- | | | |
|-------------------------------|-----------------------------|-------------|
| • Pharmacy Name/Address | • NABP number, if available | • Price |
| • Drug Name, Strength and NDC | • Patient's Name | • Rx Number |
| • Days Supply | • Date Filled | • Quantity |
- **CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.**

I certify that the information provided is correct and that the prescription(s) submitted are for me. I authorize the release of any medical information necessary to process this claim.

Subscriber's Signature: _____ Date: _____

★ **Please attach the duplicate pharmacy generated receipt or a copy of a medical expense report from the pharmacy separately.**

INSTRUCTIONS

Please attach proof of purchase pharmacy receipts for all prescriptions listed.

If you have any questions, be sure to ask the pharmacist. If you need help or to obtain additional forms, please call Rocky Mountain Health Plans Customer Service.

Customer Service

For benefit questions, we are open 8:00 a.m. to 8:00 p.m., Mountain Time, 7 days a week.

- RMHP Members residing in Colorado, call 970-244-7912 or 888-282-1420.
- If you are hearing impaired and use TTY equipment, call 711 for Relay Colorado.
- Para asistencia en español llame al 888-282-1420.

Return completed form to:

Attn: Pharmacy
Rocky Mountain Health Plans
2775 Crossroads Blvd.
P.O. Box 10600
Grand Junction, CO 81502-5600

This document is available in alternate formats, such as large print.

Medicare-approved Cost plan

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.