Rocky Mountain Health Plans®
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Medicare Part D Prescription Claim Form

Important Information – Please Read!

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

- Patient's Name
- Prescriber's Name/ID#
- Price
- Pharmacy Name, Address, ID#
- Drug Name, Strength and NDC
- Days Supply & Total Quantity
- Rx Number and Date Filled

Required Information – Please Print

1 Member Name (Last, First, Middle)	Member ID Number ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___ – ___ ___
Date of Birth: _____ _____/_____ _____/_____ _____	Daytime Telephone: ( )
☐ **Check if New Address** Street:	
City:	State: / Zip Code:
Is RMHP the primary prescription drug coverage? ☐ Yes ☐ No If no, provide the name of the primary insurance company:	
Why was the RMHP member identification card not used for this purchase?	
REQUIRED: Pharmacy Name:	Pharmacy NPI#:

2 Please complete the areas below.*

RX Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Directions	Days Supply____	RX Price
Medication Name, Form, Strength			Prescriber:		NDC Number (11 digits)	
			Prescriber NPI#:			
RX Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Directions	Days Supply____	RX Price
Medication Name, Form, Strength			Prescriber:		NDC Number (11 digits)	
			Prescriber NPI#:			
RX Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Directions	Days Supply____	RX Price
Medication Name, Form, Strength			Prescriber:		NDC Number (11 digits)	
			Prescriber NPI#:			
RX Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Directions	Days Supply____	RX Price
Medication Name, Form, Strength			Prescriber:		NDC Number (11 digits)	
			Prescriber NPI#:			

***If submitting compounded drugs, attach page 3, <u>Compound Prescription Form</u> for each compound.**
***If submitting Medicare Part D vaccines, attach page 4, <u>Vaccine Form.</u>**

Special Instructions:

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3 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: _________________

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.

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.

Return completed form to:

MedImpact Healthcare Systems, Inc.
PO Box 509098
San Diego, CA 92150-9098
Fax: 858-549-1569
E-Mail: Claims@Medimpact.com

Customer Service

For benefit questions, we are open 8:00 a.m. to 8:00 p.m., Mountain Time, 7 days a week from October 1st through February 14th. Hours from February 15 through September 30 are 8:00 a.m. to 8:00 p.m., Mountain Time, Monday through Friday.

- 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.

RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.

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.

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Medicare Part D Compound Prescription Form

Member Name (Last, First, Middle)	Member ID Number
	___ ___ ___ – ___ ___ – ___ ___ ___ ___ – ___ ___

The pharmacy or dispensing facility must complete the remaining portion of this form and return it to the member/patient or provide the member/patient with a Universal Claim Form for a Compounded Medication.

- Indicate the metric quantity dispensed in number of tablets, grams or milliliters for liquids, creams, ointments or injectables.
- Indicate all ingredients in the compound.
- The original pharmacy prescription label should accompany this claim form or the Universal Claim Form.

Please provide the following for compounded prescription claims:

RX#:		**Date of RX Fill:**	
NDC# (11-digit)	**Drug/Ingredient**	**Quantity**	**Charge**
		Total Charge	**$**

RX#:		**Date of RX Fill:**	
NDC# (11-digit)	**Drug/Ingredient**	**Quantity**	**Charge**
		Total Charge	**$**

Filled out by (printed name): ____ **Date:**____________________________

Name of Pharmacy: ____

Address: ____ **Phone:** _________________________

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Medicare Part D Vaccine Form

Member Name (Last, First, Middle)	Member ID Number
	___ ___ ___ – ___ ___ – ___ ___ ___ ___ – ___ ___

The clinic, pharmacy or dispensing facility must complete the remaining portion of this form and return it to the member/patient to submit for reimbursement for Medicare Part D covered vaccines.

Name of Physician: ______________________________

Physician NPI#: ______________________________

Brand name of vaccine administered: ______________________________

NDC # for vaccine administered: ______________________________

Date vaccine administered: ______________________________

Reason for vaccine: ☐ Routine / preventative ☐ Treatment for injury or illness

Member price of vaccine: ______________________________

Member administration fee for vaccine: ______________________________

Brand name of vaccine administered: ______________________________

NDC # for vaccine administered: ______________________________

Date vaccine administered: ______________________________

Reason for vaccine: ☐ Routine / preventative ☐ Treatment for injury or illness

Member price of vaccine: ______________________________

Member administration fee for vaccine: ______________________________

Internal Use

Special Instructions: ______________________________

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