HealthPartners®

Prescription Drug Reimbursement Form

Please complete all information. An incomplete form may delay your reimbursement.
Manual submission of claims does not guarantee reimbursement.

You are not required to use this form. You may submit other documentation that provides the requested information.

Prescription(s) were for:

Last name, First, Middle Initial	Member Number	Date of Birth
Address Street	City	State Zip

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process the claim.

Signature:_____ Date:_____

Reason for Reimbursement:

☐ I did not have my insurance card at the time of purchase.
☐ Pharmacy not participating in network.
☐ Pharmacy unable to process the claim electronically.
☐ I believe the claim was paid incorrectly. (Please explain)

_____
_____

☐ I have drug coverage with a plan other than HealthPartners. (Coordination of Benefits)
Must fill out **Prescription Information below to receive proper claims processing**
Primary carrier name: _____ Primary carrier phone number: _____
☐ I was charged for medications received during an Emergency Room visit.
☐ Other:_____

_____

Prescription Information: (please tape detailed pharmacy receipt(s) on a separate sheet of paper.)

A detailed pharmacy receipt(s) (pharmacy printout) should contain the following information:

- Pharmacy Name, Address and Phone Number
- Date Prescription Filled
- Prescription (RX) Number
- NDC Number(a ten-digit, three-segment number used to identify a drug)
- Drug Name and Strength
- Quantity
- Days Supply
- Doctor name or ID number
- Amount billed by pharmacy (Usual & Customary U&C)
- Amount Paid by other insurer (Primary Insurer)

1. Each patient must have their own Prescription Drug Reimbursement Form.
2. Claims must be submitted in the timeframe required by your plan.
3. For timely processing, please include all of the information listed above.
   - ✳ Your pharmacy may provide the necessary detailed receipt information if it is not itemized on your claim or bill. A pharmacist's signature will be required.

Commercial Mailing Information:

Return the completed form and receipt(s) to:
HealthPartners Claims Department – 25510 F
PO Box 1289
Minneapolis, MN 55440-1289
Fax number: 651-265-1230
Visit us on the web at **healthpartners.com**

Medicare Part D Mailing Information:

Return the completed form and receipt(s) to:
HealthPartners Claims Department – 21103 R
PO Box 9463
Minneapolis, MN 55440-9463
Fax number: 952-883-7666

Y0095 S1822_83813 IR Approved 10/15/2014