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.

Last name, First, Middle Initial	Member Number	Date of Birth
Member Street, City, State and 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)
  Primary carrier name: _____ Primary carrier phone number: _____
* I was charged for medications received during an Emergency Room\Outpatient Hospital visit.
* Other:_____

Prescription Information: Include a detailed pharmacy receipt(s)/hospital bill that includes the following information:

- **Proof of Payment.** Include a receipt showing payment in full.
- Pharmacy/Facility 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
- Day Supply
- Doctor name or NPI 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. Check your contract or call member services if you are unsure what the timeframe for your plan is.
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.

Mailing Information – Return the completed form and receipt(s) to:

HealthPartners Pharmacy Administration Department
Mail Stop: 21111B
8170 33rd Avenue South
Bloomington, MN 55440-1309
Fax number: 952-853-8700
Visit us on the web at **healthpartners.com/medicare**

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