KanCare | Healthy Blue | carelon Rx

Prescription Reimbursement Claim Form

Important:

- Allow up to 30 calendar days for processing to receive a response to your claim
- Keep a copy of all documents submitted for your records
- Do not staple receipts or attachments to this form
- Reimbursement is not guaranteed and may not equal the amount paid
- You must submit claims within 1 year of date of purchase or as required by your plan

STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number (refer to your member ID card)

Group Number/Group Name

Last Name

First Name MI

Address

Address 2

City

State Zip Country

Patient Information–Use a separate claim form for each patient

Last Name

First Name MI

Date of Birth Male Female Phone Number

Relationship to Primary Member

Member Spouse Child Other _____

Pharmacy Information–Use a separate claim form for each pharmacy

Pharmacy Name

Address

City State Zip

REQUIRED: Please check appropriate box for submitting a paper claim. Claim will be returned if incomplete. (Tape receipts and/or itemized bills on another sheet of paper)

Reason I am filing this form is:

- ☐ Claim rejected at pharmacy
- ☐ Compound
- ☐ Out of coverage area
- ☐ Other–provide reason below

_____

_____

_____

PLEASE INDICATE:

State:_____

Other Insurance Information

Coordination of Benefits (COB)

Are any of these medicines being taken for an on-the-job injury? ☐ YES ☐ NO

Is the medicine covered under any other group insurance? ☐ YES ☐ NO

If YES, is other coverage:

☐ PRIMARY ☐ SECONDARY

☐ MEDICARE PART D

If other coverage is PRIMARY, include the Explanation of Benefits (EOB) with this form.

Name of Insurance Company:

_____

_____

ID#: _____

Continued

Pharmacy Information Continued

Phone Number

Is this an on site nursing home pharmacy? YES NO

NCPDP/NPI Required

x

Signature of Pharmacist or Representative (REQUIRED)

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

x

Signature of Plan Participant (REQUIRED) Date

STEP 2 Submission Requirements

You MUST include all original "pharmacy" receipts for your claim to be reviewed.

The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Date of Fill
- Prescription Number
- Amount and Type of Drug (4 tablets, for example)
- Medicine NDC Number
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this "Days Supply" information)
- Pharmacy Name and Address or Pharmacy NCPDP Number

Please provide a valid Prescribing Physician's NPI: _____

Prescribing physician's information:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Additional comments: _____

_____

STEP 3

Mail completed forms with receipts to:

Claims Department
P.O. Box 52065
Phoenix, AZ 85072-2065

OR

Fax completed forms with receipts to:

Fax: 401-404-6344

IMPORTANT REMINDER – To avoid having to submit a paper reimbursement claim form:

- Always have your ID card available at time of purchase
- Use medication from your preferred drug list
- If problems are encountered at the pharmacy, call the Pharmacy Member Services number on your ID card
- Always use pharmacies within your plan
- Return to the pharmacy to request claim reprocessing and for reimbursement

Services provided by CarelonRx, Inc.
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RESET FORM