INSTRUCTIONS

• To process your claim as quickly as possible, please provide all information requested.
• Ask your pharmacist for the drug information on this form. Prescription receipts or a pharmacy-generated drug summary must be attached. Cash register receipts are not acceptable.
• Find your identification number on your member ID card.
• Use a separate claim form for each patient and pharmacy.
• Fill out all fields for each submitted prescription.
• NPI – National Provider Identifier – a 10-digit identification number assigned to health care providers.

Example of how to complete the Prescription Drug Claim Form

1 Rx Number: 000006011481
Date Filled: 10/01/2013
Quantity: 60 Day Supply: 30
Name of Medication: “Drug Name”
NDC Number: 00186502228
NPI Number: 9215241163
Prescription Cost: $146.04
Balance Due: $0

• If additional claim forms are needed, call Member Services at the number listed on the back of your member ID card.
• Mail your completed claim form and prescription receipts to:
  Part D Claims
  P.O. Box 14429
  Lexington, KY 40512-4429

If you need information or help, call us at:
  Toll Free: 1-800-391-1906
  TTY: 711
  24 hours a day, 7 days a week.

Other resources to help you:
  1-800-MEDICARE (1-800-633-4227)
  TTY/TDD: 1-877-486-2048, available 24 hours/day, 7 days/week except federal holidays.

CLAIM SUBMISSION

• DO NOT include charges for durable medical equipment. DO NOT submit canceled checks. DO NOT submit cash register slips. These are not acceptable as substitutes for original receipts. DO NOT submit statements with balance amounts only.

HOW TO COMPLETE THIS FORM

• Your member ID number can be found on your member ID card.
• Sign and date in the space provided. Your signature certifies that the information is correct and complete.
• Please make a copy of all documents and receipts before you send in your claim(s). No documents will be returned.

COMPOUND INFORMATION

• If a compound prescription, enter the NDC number for the most expensive ingredient.

<table>
<thead>
<tr>
<th>NDC number</th>
<th>Drug ingredient</th>
<th>Quantity</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

I certify that:
The information on this form is correct. The member listed here is eligible for benefits and has received these medications. I approve the release of information on this form to Prime Therapeutics. I agree that any benefits payable here for prescription drugs are not assignable. I agree that any further assignment shall be void. I also state that there has been no assignment of these benefits.

X
Member Signature

Date

Health Care Fraud Notice – Fraud Hotline at 1-800-706-4071. TTY/TDD 1-800-693-3816. Monday through Friday, 8 a.m. to 5 p.m. CT. Health care fraud affects us all and causes an increase in health care costs. If you know or suspect any type of health care insurance fraud, please call us at the fraud hotline. All calls are confidential. You may report your concerns anonymously via our toll free hotline.
**MEDICARE PRESCRIPTION DRUG CLAIM FORM**

### MEMBER INFORMATION
- **Date of Birth**: 
- **Identification (ID) Number**: 
- **Member Name (First, Last)**: 
- **Street Address**: 
- **City  State  ZIP**: 

### OTHER HEALTH INSURANCE INFORMATION
- **Is this medication for an on-the-job injury?**: Yes [ ] No [ ]
- **Is this medication related to an auto accident?**: Yes [ ] No [ ]
- **Do you have other insurance that includes prescription drug coverage?**: Yes [ ] No [ ]

If yes, please submit claim form with both items below:
1. Copy of both sides of other health insurance ID card
2. Explanation of Benefits (EOB) from other health insurance. Please include amount paid and/or rejection of these prescriptions.

### Was an out-of-network pharmacy used? Yes [ ] No [ ]
If yes, provide reason below:
- I was traveling within the United States, but outside of the Plan’s service area. I became ill or lost or ran out of my prescription drugs.
- I was unable to get a covered drug in a timely manner. There was not a network pharmacy nearby that provided 24/7 service.
- I was trying to fill a covered drug not regularly stocked at a network retail or mail order pharmacy. (This might include orphan drugs or specialty pharmaceuticals.)
- I was a patient in one of these:
  - Emergency department
  - Provider-based clinic
  - Outpatient surgery
  - Other outpatient setting

### PRESCRIPTION CLAIM INFORMATION
Original pharmacy receipts are required. Do not staple.
- **Is this prescription claim for a compound medication?**: Yes [ ] No [ ]

Note: If yes, make sure your pharmacist lists the NDC number for the active ingredient.

Receipts must include:
- Pharmacy name [ ]
- Strength [ ]
- Drug name [ ]
- Date purchased [ ]
- Quantity [ ]
- Drug charge [ ]
- NDC number [ ]
- Days supply [ ]
- NPI number [ ]
- Prescription number [ ]
- OHI Paid Amount (if COB) [ ]

All fields below must be completed. Call your pharmacist if you need assistance.

<table>
<thead>
<tr>
<th>Rx Number</th>
<th>Date Filled</th>
<th>Quantity</th>
<th>Day Supply</th>
<th>Name of Medication</th>
<th>NDC Number</th>
<th>NPI Number</th>
<th>Prescription Cost</th>
<th>Balance Due</th>
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