Prescription Reimbursement Claim Form

Please note:

- It may take up to 30 days from when you sent this form to get a response back. This allows for mail and processing time
- Make a copy of this form, all receipts, and other documents. Keep them for your records
- Don't staple or tape any receipts or other documents to this form
- Submitting this claim doesn't mean you will be reimbursed. The contractor will review your request which must meet certain plan rules, limits, and exclusions

STEP 1 Card Holder/Patient Information

Please fill in this entire section. Incorrect or blank items can slow or stop your claim.

Card Holder Information

Identification Number **Group No./Group Name**

Name *(Last Name)* *(First Name)* *(MI)*

Address

Address 2

City **State** **Zip**

Country

Patient Information-Use a separate claim form for each patient.

Name *(Last Name)* *(First Name)* *(MI)*

Date of Birth **Male** ☐ **Female** ☐ **Phone Number**

Relationship to Enrollee

Self ☐ Spouse/Domestic Partner ☐ Child ☐

Other Insurance Information

COB (Coordination of Benefits)

Were any of these medicines for an on-the-job injury? ○Yes ○No

Are any covered by another group insurance plan? ○Yes ○No

If yes, is the other plan your: ○Primary ○Secondary

If it's your primary, send in the plan's explanation of benefits with this form.

Fill in the plan name_____and your plan ID number_____

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 Enrollee **Date**

(Over)

STEP 2 Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)
- Pharmacy Name and Address or Pharmacy NABP Number

If the Prescribing Physician's NPI (National Provider Identification) number is available, please provide: _____

If this is from a foreign country, please fill in below:

Country:_____ Currency:_____ Amount:_____

Additional Comments

STEP 3 Mailing Instructions:

Please mail your completed claim form and supporting receipt to the address below:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

IMPORTANT REMINDER

You can avoid having to submit paper claim forms by:

- Always having your prescription ID card with you
- Always using in-network pharmacies (find them at Caremark.com)
- Using covered medicine (see plan's drug list)

- Calling the number on the back of your ID card if there are issues at the pharmacy

Non-Discrimination Notification

Molina Healthcare of Florida, Inc.

Medicaid

Discrimination is against the law. Molina Healthcare of Florida, Inc. (Molina) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Molina:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Molina Member Services at (866) 472-4585 (TTY: 711).

If you believe that Molina has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
200 Oceangate, Ste 100
Long Beach, CA 90802
Phone: (866) 472-4585 (TTY: 711)
Fax: (877) 508-5738
Email: **civil.rights@molinahealthcare.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Molina Member Services is available to help you. You may obtain our grievance procedure by visiting our website at: **https://www.molinahealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: (800) 368-1019 (TDD: (800) 537-7697)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Non-Discrimination Tag Line – Section 1557

Molina Healthcare of Florida, Inc.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (866) 472-4585 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (866) 472-4585 (TTY: 711).
French Creole (Haitian Creole)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (866) 472-4585 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (866) 472-4585 (TTY: 711).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (866) 472-4585 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (866) 472-4585（TTY：711）。
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (866) 472-4585 (TTY : 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (866) 472-4585 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (866) 472-4585 (телетайп: 711).
Arabic	ةظوملحة: اذإ تكن ركذا ثدحتت غةللا، نإف تامدخ ةدعاسملا ةيوغللا رفاوتت نماجملاب كلا. لتصا مقرب (866) 472-4585 (مقر فتاه مصلا مكبلاو: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (866) 472-4585 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (866) 472-4585 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (866) 472-4585 (TTY: 711) 번으로 전화해 주십시오.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (866) 472-4585 (TTY: 711).
Gujarati	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (866) 472-4585 (TTY: 711).
Thai	เรยน: ถาคณพดภาษาไทยคณสามารถใชบรการชวยเหลอทางภาษาไดฟร โทร (866) 472-4585 (TTY: 711).

MOLINA HEALTHCARE