Medicare Part D Coordination of Benefits / Direct Claim Form

See the back for instructions. Complete all information. An incomplete form may delay your reimbursement. If you are not a Medicare Part D member and complete this form, it may delay the processing of your claim.

WPS HEALTH INSURANCE

Member/Subscriber Information *See your prescription drug ID card*

Group No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last)

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Date of Birth **(MM/DD/YYYY)** ☐☐ ☐☐ ☐☐☐☐

Pharmacy Information

Name of Pharmacy

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

National Provider ID Number: _____

Request for a True Out-of-Pocket (TrOOP) Update

This section is not required for a direct claim reimbursement. Please complete this section only if you have a request for a TrOOP update. (If you have a direct claim and this area is completed, your reimbursement will be delayed.)

1. Please include all applicable pharmacy receipts and/or Explanation of Benefits statements with this form.
2. Check off which of the payers below paid your claim.
   - ☐ A discount card
   - ☐ A Patient Assistance Program (PAP)
   - ☐ A secondary payer
3. Complete the Other Coverage Section on the back of this form.

Does this claim qualify for coverage?

You may submit a claim for Part D–covered medication dispensed by a nonparticipating pharmacy only for the reasons listed below. Please check the box that applies to your situation:

- ☐ **A.** I traveled outside my plan's service area and ran out of (or lost) my medication/ I became ill and could not access a network pharmacy.
- ☐ **B.** I was unable to obtain my medication in a timely manner within my service area (there was no network pharmacy within a reasonable driving distance that provides 24/7 service).
- ☐ **C.** My medication is not stocked regularly at an accessible network or mail-order pharmacy.
- ☐ **D.** My medication was dispensed from an emergency department, provider-based clinic, outpatient surgery facility, or other outpatient setting.
- ☐ **E.** I received a vaccine at my doctor's office. (Be sure to include the receipt from the physician and complete the PHARMACY INFORMATION section on the back.)
- ☐ **F.** I was evacuated or displaced from my residence due to a State or Federally declared disaster or health emergency.

Coordination of Benefits

(Another Health Plan has paid a portion) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?

☐ Yes ☐ No

- ☐ Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid
- ☐ Card Program
- ☐ The **Medco Pharmacy**®/mail-order pharmacy

Acknowledgment

I certify that the medication described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X _____

Signature of Member

Other Coverage Section: Complete the information below only if you have requested a TrOOP Update—do not complete for direct claim reimbursements alone.

Other Insurance Company Name

Other Policy Number

Other Policy Holder Name

Date of Service	Drug Name – Rx Number	Charge	Amount Patient Paid	Amount Other Payer Paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

For compound prescriptions, you must complete the section to the right, and the pharmacy receipt must include the following:

- Name of each ingredient contained in the prescription
- A valid NDC for each ingredient
- For each NDC number, indicate cost per ingredient.
- The quantity of each ingredient (Note: If you need help getting this compound drug information, please contact your pharmacist.)

Rx #		Date filled		Days' supply	
VALID 11-digit NDC #			Quantity		Price
		Total quantity			
		Total charge			

Step-by-Step Instructions

- Complete all applicable sections on side 1.
- You must complete a separate claim form for each pharmacy used.
- Tape pharmacy receipts to an additional piece of paper; do not staple.
- You must submit claims no later than 3 months after the end of the benefit year for the date of purchase.
- Read the acknowledgment at the bottom of side 1; sign and date the form.

Return the completed form and applicable receipt(s) to:

WPS Health Insurance PDP
c/o Medco
P.O. Box 14718
Lexington, KY 40512

For standard prescriptions, the pharmacy receipt must include:

- Date prescription filled
- DAW (Dispense As Written)
- Pharmacy name and address
- Doctor name and ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- Amount paid

Other Coverage Paid: You must first submit the claim to the primary insurance carrier. Once the Explanation of Benefits (EOB) from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipt(s) on a blank sheet of paper, and enclose the EOB from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription Drug Programs or HMO Plans Card Program: If the primary plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no EOB is needed. Just complete this form and tape the prescription receipt(s) on a blank sheet of paper that shows the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

The *Medco Pharmacy:* If the primary plan is the **Medco Pharmacy,** complete this form and include either the prescription receipt(s) that show(s) the co-payment or coinsurance amount paid to the mail-order pharmacy, or the statement of benefits you receive from the mail-order pharmacy.