Prescription Drug Claim Form

NAVITUS MedicareRx (PDP)

You are not required to use this form to request a reimbursement. This form encompasses standard reimbursement requests, as well as requests for Compound Claims. If your drug is not a compound some of the requested fields may not be applicable. Please fill out as much information as you have available. ***Any blank fields we will attempt to obtain directly from your pharmacy.***

Please indicate the reason for your reimbursement request.

- ☐ I did not have my member ID card at the time of purchase.
- ☐ I was charged for medication(s) received during an urgent care/emergency visit.
- ☐ I was administered a vaccine in my doctor's office.
- ☐ Primary coverage is with another insurance carrier. (Coordination of Benefits)
- ☐ Other: _____

Part 1: Member Information

1. Complete ALL information. Your ID Number can be located on the front of your member ID card.
2. Submit claims within the filing period specified in your Evidence of Coverage. For questions about the filing period, please review your Evidence of Coverage or call Navitus MedicareRx Customer Service at 1-866-270-3877 (TTY users can call 711). Members can reach Navitus MedicareRx Customer Care 24 hours a day, 7 days a week, excluding Thanksgiving and Christmas Day.
3. Requests for reimbursement may be made by the member, the member's prescribing physician or provider, or the member's representative. If someone other than the member is requesting this reimbursement please include a completed Appointment of Representative form with your request.
4. Please submit a separate form for each patient for which you purchased medications.

First Name	Last Name	MI
Telephone Number ( )	Date of Birth	Gender (Circle One) Male Female
ID Number	Subscriber's Employer (PCN)	
Mailing Address		
City	State	ZIP Code
Member Signature		Date Signed

Part 2: Pharmacy Information/or Provider of Service

1. Complete ALL information.
2. Please submit a separate form for each pharmacy from which you purchased medications.

Name		
Street Address		
City	State	ZIP Code
Pharmacy/or Provider of Service National Provider Number (NA if not available)		Telephone Number ( )

Part 3: Receipt Information

1. Include **Proof of Payment** with the original pharmacy receipt(s) or pharmacy printout(s). Cash Register Receipt(s) without pharmacy detail will not be accepted. Tape all receipt(s) to the bottom of this page. Please DO NOT staple.
    a. Compound medications must have at least 2 ingredients, and at least 1 ingredient must be a Federal legend drug.
    b. All active ingredients must be covered as part of your formulary and all script information must be submitted.
2. Please provide the explanation of benefits (EOB) or denial letter from the primary insurance carrier if you have primary coverage with another insurance carrier.
3. Receipts will not be returned, remember to keep a copy of the completed claim form and receipt(s) for your records.

<u>Part 4: Drug Information</u>: *This information should be listed in your original pharmacy receipt, pharmacy printout, or Medical Invoice. If all required information is on the receipt, you may bypass Part 4. If the receipt or invoice is missing any of this information, please ask your pharmacist/or Medical Provider to help fill in the missing details. If you are unable to obtain the information we will attempt to contact your pharmacy, however it may result in a delay of processing your claim.*

Date Rx Filled	Diagnosis Code and Description	Medication Name
Rx Number (NA if not available)	Final Form of Compound (cream, patches, suppository, suspension, etc.)	
National Drug Code	Quantity	
Day Supply	Total Volume (grams, ml, each, etc.)	
Prescribing Physician First/Last Name		Prescribing Physician NPI (NA if not available)
Original Cost of Rx	Amount Primary Insurance Paid on Rx	Member Paid Amount

For Reimbursement of Compound Drug Preparation, see the table below.
Please indicate the time spent preparing the compound drug in the Receipt Information on page 2.

Time	Reimbursement
1 – 4 minutes	$15.00
5 – 14 minutes	$25.00
15 – 29 minutes	$35.00
30 -59 minutes	$50.00
60+ minutes	$75.00

Compound Ingredients

	Ingredient Name	Ingredient NDC	Metric Decimal Quantity	AWP/WAC
1				
2				
3				
4				
			Total Ingredient Cost	
			Preparation Time	
			Member Copay	

Reimburse (Circle One)	
Pharmacy	Member

Mail this form along with receipts to:
Navitus MedicareRx (PDP)
Manual Claims
P.O. Box 1039
Appleton, WI 54912-1039

Or Fax this form along with receipt to:
1-855-668-8550