Request for Payment of Pharmacy Services

MEMBER INFORMATION

First name	Middle initial	Last name	Date of birth MM/DD/YYYY
Street			
City		State	ZIP
Member ID number	Home telephone ( )	Work telephone ( )	Sex ❑ Male ❑ Female

PRESCRIPTION INFORMATION (See your prescription label for details.)

Please note that we cannot process your request unless this entire section is completed.

Date filled MM/DD/YYYY	Days supply *(ask your pharmacist for this information)*
Rx number	Metric quantity
NDC number	
Prescribing physician name	Prescriber NPI number

Prescriber street address			**Charge**	**Amt. paid**
City				
State	ZIP	Prescriber telephone ( )		
Pharmacy name and address or pharmacy NABP number			**Total**	**Total**

OTHER INSURANCE

Are you covered by other insurance (other than Medicare and/or Medicaid)? ❑ Y ❑ N

If yes, number: _____

If yes, name and address of carrier _____

_____

Is the claim due to

- an automobile accident? ❑ Y ❑ N Please explain: _____
- any other type of accident? ❑ Y ❑ N Please explain: _____
- an occupational injury or illness? ❑ Y ❑ N

Comments: _____

_____

AUTHORIZATION RELEASE

I, the undersigned, hereby authorize any physician, hospital, insurer, or other organization or person having any medical or other records, data or information concerning me or my minor dependent to furnish such records, data or information to Fallon Health. I understand that in executing this authorization, I waive all claim and right of privilege with regard to such information. A photocopy of this authorization shall be considered as effective and valid as the original bearing my signature.

Member/Authorized Representative signature _____ Date _____

See reverse for instructions.

Instructions for submitting your Request for Payment of Pharmacy Services

Follow these easy steps:

1. **Include** some proof of payment such as a canceled check (front and back) or paid receipt. Please don't use tape or a staple. Remember to make a copy for your records.
2. **Complete** the "Member Information" section showing your name, member ID number and other identifying information.
3. **Complete** the "Prescription Information" section.
   Include your pharmacy receipt and label from your prescription bag with this form. If you no longer have this information, please contact the pharmacy and they can provide you with a printout. **Please note:** cash register receipts will only be accepted for diabetic supplies.

   If you are requesting reimbursement for a compounded medication, you will need to complete the attached Compound Prescription Form. Bring it to your pharmacy and they can help you complete it.
4. **Complete** the "Other Insurance" section providing all information on other health insurance (if applicable), automobile accident, other accident or occupational illness/injury (workers' compensation). Please do not include Medicare and/or Medicaid coverage.
5. **Sign and date** the Authorization Release.

With complete information, payment will be received within 14 days.
We will contact you in writing if we need additional information regarding your claim.

After completing the form, please mail it with receipts to:

Med D Paper Claims
P.O. Box 52066
Phoenix, AZ 85072-2066

For questions:

Fallon Medicare Plus™ and **Fallon Medicare Plus™ Central members,** please call Customer Service at 1-800-325-5669 (TRS 711).

NaviCare® HMO SNP or SCO members, please call Enrollee Services at 1-877-700-6996 (TRS 711).

We are open 8 a.m.–8 p.m., Monday–Friday. (Oct. 1–March 31, seven days a week.)

To receive payment, forms must be submitted to us within 365 days of the date of service.

fallonhealth