MEDICARE REIMBURSEMENT FORM FOR PRESCRIPTION DRUGS

Please print clearly, complete all sections and sign. Retain copy for personal records.

1. **Member Name**:
(Last) (First) (Middle)

2. **Member I.D. Number**:
(See I.D. card)

3. **Date of Birth**:

4. **Member Sex**:
☐ M ☐ F

5. **Requestor Name (if member representative)**:
(Last) (First) (Middle)

6. **Relationship to member**:
☐ Self ☐ Spouse ☐ Disabled Dependent
☐ Dependent Parent ☐ Domestic Partner ☐ Other

7. **Member Address**:

8. **Patient's type of Kaiser Permanente Medicare insurance**:
☐ HMO ☐ PPO

9. **Address payment is to be mailed to:**

10. **Phone Number:**

11. **Primary Language**:

12. **Prescriber (Doctor) Information**:

Prescriber Name: ______________________________

Phone number: ______________________________

Fax number: ______________________________

Address:

13. **Other insurance information**:
Is the patient covered by another health plan?
☐ Yes ☐ No
Subscriber name for other insurance:
____
Name of other insurance company:
____
Member I.D. Number (See I.D. card)
____

Did other insurance make a payment?
☐ Yes ☐ No
If yes, please include ***Explanation of Benefits*** from other insurance plan(s).

Any person who knowingly and with intent to defraud, or deceive by submitting a claim containing material that is deceptive, false, or misleading information may be committing a fraudulent insurance act which is a crime. These acts may be subject to criminal or civil penalties, including fines, imprisonment, or denial of benefits.

14. **Pharmacy Information**:

Pharmacy Name: ______________________________

Phone number: ______________________________

Address:

Pharmacy NCPDP#/NPI# (US claims only):

15. **Compounded prescription**:
Is the prescription for a compounded or special order medication? ☐ Yes ☐ No

If yes, please make sure your pharmacist lists ALL the valid 11 digit NDC numbers, ingredients, and quantities on the receipt.

16. **Foreign Claims**:

For services out of the country, please provide the name of the country: ___________________________________

Where services were rendered: ☐ Office/Clinic ☐ ER ☐ Urgent Care ☐ Hospital ☐ Pharmacy
Please explain injury or illness:

Note: Itemized bills, receipts, and statements must be translated prior to submitting. Translation will be at the member's expense.

17. The following information must be obtained from your provider, or must be included on your itemized statement from your provider. Do not send originals as they will not be returned to you. Please include copies of your pharmacy receipts with this claim form. ***Receipts must contain the following information:***

- Date prescription was filled
- Pharmacy name, address and phone number
- Doctor name or ID number
- Name of medication and strength (dose)
- NDC number (drug number)
- Prescription number (Rx #)
- Quantity and days supply
- Amount paid

Prescription Medication Reimbursement information:

Date filled	**Prescriber Name**	**Medication Name**	**Strength**	**NDC #**	**Qty**	**Amt Paid**

Proof of payment is required. Please include a copy of the receipt with the pharmacy name and address preprinted on the receipt.

18. **Signature is required:**
I attest that the above information is true and accurate, and the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims. For any questions, please contact Medicare Member Services toll-free at 1-888-901-4600, (TTY Relay: 711 or 1-800-833-6388) or visit kp.org/wa/medicare, for additional contact information.

Signature: ____ **Date**:__________________________

Itemized receipts, **invoices**, and **proof of payment** must be submitted, otherwise form may be sent back for lack of information. Submit all documents to:

Pharmacy Help Desk Prescription Claims
Kaiser Permanente
P.O. Box 34990
Seattle, WA 98124-1990

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance.