Pharmacy Direct Member Reimbursement Claims Form

Section 1: Member information

Section 1 instructions:

1. Please fill out this section all the way and send your request within **36 months** from when your medication was filled. If you have questions about when you can send your request, please call the number on the back of your member ID card.
2. If you got the medicine from more than one pharmacy or doctor, or if you are sending a request for more than one member, please use a separate form for each pharmacy, doctor, and member.

Member ID number (required): Medicare ID number:

Date of birth (mm/dd/yyyy): Gender:

Member name (Last, First, MI):

Street address:

Phone number:

City: State: ZIP code:

Person completing form:

☐ Member ☐ Spouse ☐ Child ☐ Other:

Patient residence:

☐ Home ☐ Nursing home ☐ Assisted living ☐ Immediate care ☐ Hospice

Is the member eligible for primary prescription drug coverage from another insurance provider? ☐ Yes ☐ No

If yes:

Was the claim submitted to the other insurance provider? ☐ Yes ☐ No

Did the other insurance provider pay as the primary insurer? ☐ Yes ☐ No

Name of other insurance provider: Member ID:

iCare

INDEPENDENT CARE HEALTH PLAN

iCare is a wholly-owned subsidiary of Humana

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Section 2: Pharmacy and doctor information

Section 2 instructions:

1. Please give the name of the pharmacy where you got your medicine and the name of the doctor who gave you the prescription. If you do not know this information, you can ask you pharmacy or doctor for help.

Pharmacy information		
Pharmacy name:	Pharmacy NCPDP or NPI:	
Street address:	Phone number:	
City:	State:	ZIP code:
Pharmacy service type:		
☐ Retail ☐ Compounding ☐ Home infusion ☐ Institutional ☐ Long-term care		
☐ Managed care organization ☐ Mail order ☐ Specialty		

Doctor information		
Doctor name:	Doctor NCPDP or NPI:	
Doctor tax ID:	Phone number:	
Street address:		
City:	State:	ZIP code:

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Section 3: Drug information

Section 3 instructions:

1. Please answer all questions for each medicine listed below. If you do not fill in everything, we cannot review your request. If you do not know an answer, ask your pharmacy for help.

2. Attach your pharmacy receipt and proof of payment. Tape the receipt to a different page and turn it in with this form. If you got the medicine in the emergency room or doctor's office, include a detailed note from them.

Note: Medicare does not pay for services received outside the United States.

Is this a compound medication? ☐ Yes ☐ No
If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No
If yes: Vaccine cost: $ Admin. fee: $

National Drug Code (NDC): Drug name: Total cost: $

Fill date (mm/dd/yyyy): Rx number: Qty: Day supply:

Dosage form: Strength:

Dispense as written code (if applicable):

Is this a compound medication? ☐ Yes ☐ No
If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No
If yes: Vaccine cost: $ Admin. fee: $

National Drug Code (NDC): Drug name: Total cost: $

Fill date (mm/dd/yyyy): Rx number: Qty: Day supply:

Dosage form: Strength:

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Dispense as written code (if applicable):

Is this a compound medication? ☐ Yes ☐ No
If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No
If yes: Vaccine cost: $ Admin. fee: $

National Drug Code (NDC): Drug name: Total cost: $

Fill date (mm/dd/yyyy): Rx number: Qty: Day supply:

Dosage form: Strength:

Dispense as written code (if applicable):

Is this a compound medication? ☐ Yes ☐ No
If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No
If yes: Vaccine cost: $ Admin. fee: $

National Drug Code (NDC): Drug name: Total cost: $

Fill date (mm/dd/yyyy): Rx number: Qty: Day supply:

Dosage form: Strength:

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Dispense as written code (if applicable):

Section 4: Reason for request

- ☐ Pharmacy will not accept my *i*Care plan
- ☐ I did not have my plan information at the time of purchase
- ☐ I was charged for drugs received during an ER visit
- ☐ I believe the claim was paid incorrectly
- ☐ I received a drug while on a cruise **(Cruise itinerary must be included with request)**
- ☐ I received a Part D covered vaccine in my doctor's office
- ☐ I filled my medication during a natural disaster or state of emergency
- ☐ Other:

Pharmacy Direct Member Reimbursement Claims Form

Please further explain the issue:

Important claim notice

Caution: If someone lies or hides important facts when asking for insurance or making a claim and does it on purpose to trick the insurance company or another person, this is fraud. This is against the law.

Section 5: Sign and return

Note: If someone other than the member signs this form, we need extra papers to show that person can sign for the member. This could be an Appointment of Representative (AOR) form, a Power of Attorney (POA), or other legal papers. You can find an AOR form at **icarehealthplan.org**

Member signature:	Date:

Return the completed **form** and **receipt(s)**: **Mail:**
Independent Care Health Pharmacy Solutions
1555 N. RiverCenter Drive, Suite 206
Milwaukee, WI 53212
Fax: 888-599-2730

You may not get all your money back. The amount you get depends on what you paid at the pharmacy and what your *i*Care plan covers for that medicine. If you paid more than the plan covers, you will get less back. For more details, you can read *i*Care's DMR policy at: **https://www.humana.com/pharmacy/prescription-coverages/medicare-drug-list**.

Customer Service Information
Call toll free: 800-777-4376
TTY users call: 711
Hours of operation: 24 hours a day, 7 days a week.

Notice of Non-Discrimination

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Independent Care Health Plan:

- 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, or language assistance services contact **1-800-777-4376 (TTY: 1-800-947-3529)**. If you believe that Independent Care Health Plan. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail, fax, or email with Independent Care Health Plan's Non-Discrimination Coordinator at 1555 North RiverCenter Drive, Suite 206, Milwaukee, Wisconsin 53212, **1-800-777-4376 (TTY: 1-800-947-3529)**, Fax: 1-414-918-7589, or **advocate@icarehealthplan.org**. If you need help filing a grievance, Independent Care Health Plan's Non-Discrimination Coordinator can help you.

You can also file a 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, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**

This notice is available at **www.icarehealthplan.org**.

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **1-800-777-4376 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **1-800-777-4376 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **1-800-777-4376 (TTY: 711)**:

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **1-800-777-4376 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **1-800-777-4376（听障专线：711**）。

繁體中文 [Traditional Chinese]：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **1-800-777-4376（聽障專線：711）**。

Kreyòl Ayisyen [Haitian Creole]: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **1-800-777-4376 (TTY: 711)**.

Hrvatski [Croatian]: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **1-800-777-4376 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **1-800-777-4376 (TTY: 711)** تماس بگیرید.

Français [French] : Des services gratuits linguistiques, d’aide auxiliaire et de mise au format sont disponibles. Appeler le **1-800-777-4376 (TTY: 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **1-800-777-4376 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **1-800-777-4376 (TTY: 711)**.

ગુજરાતી [Gujarati]: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **1-800-777-4376 (TTY: 711)** પર કૉલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **1-800-777-4376 (TTY: 711)**

हिन्दी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **1-800-777-4376 (TTY: 711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **1-800-777-4376 (TTY: 711)**.

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **1-800-777-4376 (TTY: 711)**.

This notice is available at **www.icarehealthplan.org**.

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日本語 [Japanese]:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**1-800-777-4376 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ **1-800-777-4376 (TTY: 711)**។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **1-800-777-4376 (TTY: 711)**번으로 문의하십시오.

ພາສາລາວ [Lao] ມີການບໍລິການດ້ານພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ຟຣີ. ໂທ **1-800-777-4376 (TTY: 711)**.

Diné [Navajo]: Saad t’áá jiik’eh, t’áadoole’é binahjį’ bee adahodooníłígíí diné bich’į’ anídahazt’i’í, dóó łahgo át’éego bee hada’dilyaaígíí bee bika’aanída’awo’í dahólǫ. Kohjį’ hodíilnih **1-800-777-4376 (TTY: 711)**.

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **1-800-777-4376 (TTY: 711)**.

Português [Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **1-800-777-4376 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **1-800-777-4376 (TTY: 711)** ‘ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **1-800-777-4376 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **1-800-777-4376 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **1-800-777-4376 (TTY: 711)**.

தமிழ் [Tamil]: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **1-800-777-4376 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **1-800-777-4376 (TTY: 711)** కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **(TTY: 711) 1-800-777-4376**

Tiếng Việt [Vietnamese]: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **1-800-777-4376 (TTY: 711)**.