Magellan COMPLETE CARE.

Medicare Part D Prescription Drug Claim Form

PLEASE READ THE FOLLOWING INSTRUCTIONS AND CAREFULLY COMPLETE THE FORM. YOU ARE NOT REQUIRED TO USE THIS FORM FOR REIMBURSEMENT. YOU MAY SUBMIT OTHER DOCUMENTATION THAT PROVIDES ALL OF THE REQUESTED INFORMATION.

Use this form to request reimbursement for Part D prescription drugs if you did not receive coverage at a pharmacy. Please check the reason for your claim below:

	I have not received my ID card.
	The pharmacy is not in the MCC of AZ (HMO SNP) network.
	The pharmacy cannot process the claim electronically.
	It was an emergency—please describe the emergency on a separate sheet of paper.
	The pharmacy or payer system was down.
	I did not have my ID card and the pharmacy could not verify eligibility.
	There was no network pharmacy available where the prescription could be filled.
	Other—please describe on a separate sheet.

INSTRUCTIONS

1. Please complete a separate claim form for each member and each prescription.
2. Complete and sign each claim form.
3. When you have completed this form, please include your itemized receipts.
   - Send original receipts only.
   - Photocopies of receipts are not acceptable, unless submitted with another carrier's explanation of benefits or notice of payment.
   - A pharmacist's signature is required on all handwritten receipts.
   - Do not staple or tape receipts or attachments to this form.
4. Only claims for prescriptions purchased from a retail pharmacy are to be sent to the address on the front. Claims for all other services should be sent to your local insurance carrier. Examples of claims sent to your insurance carrier include:
   - Drugs dispensed by a physician or hospital
   - Durable medical equipment
5. Please mail the completed Claim Form with your itemized receipts to:

   Magellan Rx Medicare
   P.O. Box 1748
   Maryland Heights, MO 63043
6. Magellan Rx Medicare will contact you should you submit incomplete information and we are unable to obtain the information from your pharmacy or physician.

7. Magellan Rx Medicare will process your complete claim within 14 days and notify you of the determination. Please allow additional time for mail time.
8. It is important that you keep a copy of all documents submitted for your records.

Call MCC of AZ (HMO SNP) at 1-800-424-4509 (TTY 711) or visit us at http://www.mccofaz.com/dsnp with any questions or concerns.

CARDHOLDER – MEMBER INFORMATION

<table>
<tr><td colspan="3">Last Name:</td><td colspan="2">First Name:</td><td>MI:</td><td>Date of Birth:</td><td>Gender:</td></tr>
<tr><td colspan="3">Group Number:</td><td colspan="2">Enrollee ID:</td><td colspan="3">Effective Date of Coverage:</td></tr>
<tr><td colspan="5">Street Address:</td><td>City:</td><td>State:</td><td>ZIP:</td></tr>
<tr><td colspan="5">Mailing Address: (If different than Home Address)</td><td>City:</td><td>State:</td><td>ZIP:</td></tr>
<tr><td colspan="2">Is either address new?</td><td colspan="2">If yes, which address?</td><td colspan="2">Do you have other Insurance Coverage?</td><td colspan="2">□ Primary</td></tr>
<tr><td>□ Yes</td><td>□ No</td><td>□ Home</td><td>□ Mailing</td><td>□ Yes</td><td>□ No</td><td colspan="2">□ Secondary</td></tr>
</table>

OTHER INSURANCE COVERAGE INFO

Are you eligible for primary prescription drug coverage from another insurance company?

☐ Yes ☐ No

If yes, please complete the following information:

Other Insurance Company's Name:	Group Number:	Enrollee ID:	Effective Date of Coverage:

PRESCRIPTION INFO

<table>
<tr><td>Prescription Number:</td><td colspan="2">Date Written:</td><td>Date of Service:</td><td colspan="2">Compound?
☐ No ☐ Yes</td></tr>
<tr><td colspan="4">Drug /Product Name/Description:</td><td>Drug Strength:</td><td>Qty Dispensed:</td><td>Days' Supply:</td></tr>
<tr><td colspan="2">Product ID/NDC Number:</td><td colspan="3">Dispense as Written:
☐ No ☐ Yes</td><td colspan="2">Amount Paid:
$</td></tr>
</table>

PRESCRIBER INFO

Name:	NPI:	Phone Number:	
Street Address:	City:	State:	ZIP:

PHARMACY INFO

(***By completing this section, you certify the information contained on this form accurately represents the amount paid by the member for the prescription dispensed. You acknowledge that all payments related to these prescriptions will be paid to the member***):

Pharmacy Name:	Service Provider ID:	☐ NCPDP ☐ NPI	Phone Number:	
Street Address:	City:		State:	ZIP:

If you are not able to submit original pharmacy receipts, please have your pharmacist complete and sign below:

Pharmacist Signature:	Date:	Patient Residence Code:	Submission Clarification Code:

ENROLLEE SIGNATURE

NOTICE: Reimbursement for this drug claim is subject to your prescription benefit program and not guaranteed. Reimbursement will be made according to the limits of your prescription drug plan and will be for the amount your program would have paid on your behalf if the prescription drug is covered.

Any person who knowingly and with intent to defraud, inure or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act, which may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or the individual for whom I am the Authorized Representative) have received the medicine described herein. I certify that I have read and understood this form, and that all the information included on this form is true and correct.

Enrollee/Representative Signature:	Date:

Call MCC of AZ (HMO SNP) at 1-800-424-4509 (TTY 711) or visit us at http://www.mccofaz.com/dsnpwith any questions or concerns.

REMINDER: To avoid having to submit a paper claim:

- ✓ Always have your prescription drug card at the time of purchase
- ✓ Always use pharmacies in your network
- ✓ Use medication covered under your formulary