Enrollee Prescription Drug Claim Form

REASON FOR REIMBURSEMENT

This claim form can be used to request reimbursement of covered expenses. You may select one of the reasons below to tell us more about your request. Note that the use of a claim form, such as this Enrollee Prescription Drug Claim Form, is not required to receive a reimbursement.

☐ I did not use my prescription drug ID card
☐ Non-participating pharmacy (Please explain)
_____
☐ Primary coverage is with another insurance carrier. Please provide explanation of benefits (EOB) or denial letter from the primary insurance carrier

☐ I was waiting for a drug approval
☐ I was retroactively enrolled with the plan
☐ I filled a compound prescription (Please have your pharmacist fill out the compound prescription area of this form)
☐ Other/explanation:_____

ENROLLEE INFORMATION

ID number (on the front of your prescription drug ID card): _____
RxPCN (on the front of your prescription drug ID card): _____
Enrollee name: _____
Enrollee birth date: Month _____ Day _____ Year _____ Enrollee sex: ☐ Male ☐ Female

ENROLLEE CERTIFICATION

I represent that the enrollee information entered on this form is correct, that the enrollee named is eligible for the benefits and that the enrollee has received the medication described. I also represent that the medication received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees. Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.
Enrollee signature: _____ Date: _____
Daytime phone number:_____

PRESCRIPTION INFORMATION

Use this section for brand and generic medication refund requests.
(See the next section for compound prescription refund requests.)

1) Date Filled	Rx Number	Quantity	Day Supply
Drug Name and Strength		11-digit NDC number	Amount Paid $
Prescribing doctor's name			Doctor's phone number
Pharmacy name and address			Pharmacy NABP

2) Date Filled	Rx Number	Quantity	Day Supply
Drug Name and Strength		11-digit NDC number	Amount Paid $
Prescribing doctor's name			Doctor's phone number
Pharmacy name and address			Pharmacy NABP

COMPOUND PRESCRIPTION INFORMATION

This section is only for multi-ingredient compound prescription refund requests. The drug information should be completed by the dispensing pharmacy. A pharmacy-generated receipt should accompany each request.

1) Date filled	Rx Number	Dispensing fee $	Total amount paid $
Prescribing doctor's name			Doctor's phone number
Pharmacy name and address			Pharmacy NABP

Ingredient	11 – digit NDC	Drug Name	Metric Quantity	Amount Paid

Pharmacist signature:_____

INSTRUCTIONS

1. Fully complete all sections of this form. Submit a separate form for each request.
2. Sign and date the Enrollee Certification statement in the area provided.
3. If you do not have detailed prescription receipts for each medication related to your request, you can ask your pharmacist for a replacement receipt or a patient printout.
4. The Prescription Information section can be completed for each prescription for which you are seeking reimbursement.
5. If you filled a compound medication, your pharmacy should fill out the designated section of this form. If your prescription is not a compound medication, there is no need to complete the compound prescription section.
6. Claims missing information may be denied. Remember to send detailed prescription receipts or a pharmacy printout. Please note that cash register receipts alone are not acceptable.
7. If you need help completing this form, contact your pharmacist.
8. **Make a copy of your prescription receipts. Keep a copy for your records.**
9. You should mail your request to:
   Cigna Medicare
   Attn: Medicare Part D
   P.O. Box 14718
   Lexington, KY 40512-4718
10. Questions? Please call the customer service number located on your prescription drug ID card.

ATTENTION: If you speak English, language assistance services, free of charge are available to you. Call 1-800-627-7534 (TTY 711), October 1 – March 31, seven days a week, 8 am–8 pm local time. April 1st – September 30th, Monday – Friday, 8 am–8 pm local time (a voicemail system is available on weekends and holidays). Cigna Medicare Services complies with applicable Federal civil rights laws, and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-7534 (TTY 711), desde el 1 de octubre hasta el 31 de marzo, los siete días de la semana, de 8:00 a. m. a 8:00 p. m., hora local. Desde el 1 de abril hasta el 30 de septiembre, de lunes a viernes, de 8:00 a. m. a 8:00 p. m., hora local (los fines de semana y días festivos hay un sistema de correo de voz disponible). Cigna Medicare Services cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.