CommuniCare ADVANTAGE

MedImpact

USE THIS FORM TO REQUEST REIMBURSEMENT FOR CLAIMS THAT YOUR PHARMACY DIDN'T PROCESS UNDER YOUR INSURANCE.

Cardholder Name: _____ Cardholder ID: _____

Patient Name: _____ Patient DOB: _____

Cardholder Address: _____ City/State: _____ ZIP Code _____

Phone Number: _____

Is this a Coordination of Benefits Claim? Yes ☐ No ☐

Internal Use Only: Episode Number:

Please include a pharmacy receipt for each medication to avoid denial and/or delays in processing your case.
A cash register receipt alone cannot be used to process your claims.

All information in the below boxes must be completed in order to avoid delay or denial of your claim.

	Medication #1		**Medication #2**	
Pharmacy NABP: (Obtain from pharmacy)			Pharmacy NABP: (Obtain from pharmacy)	
Fill Date:			Fill Date:	
RX #:			RX #:	
National Drug Code (NDC) (11 Digits)			National Drug Code (NDC) (11 Digits)	
Medication Name:			Medication Name:	
Medication Strength:			Medication Strength:	
Physician Name:			Physician Name:	
Physician NPI: (Obtain from physician)			Physician NPI: (Obtain from physician)	
Quantity/Day Supply:			Quantity/Day Supply:	
Patient Paid:			Patient Paid:	

Please provide a brief explanation regarding why you paid out of pocket for your medication(s). (Attach a separate sheet if additional space is required)

This form can be faxed to: 866-646-1403 OR This form can be mailed to:

MedImpact – DMR
7835 Freedom Avenue NW
North Canton, OH 44720

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All information in the below boxes must be completed in order to avoid delay or denial of your claim.

Additional Medication		Additional Medication	
Pharmacy NABP: (Obtain from Pharmacy)		Pharmacy NABP: (Obtain from Pharmacy)	
Fill Date:		Fill Date:	
RX #:		RX #:	
National Drug Code (NDC) (11 Digits)		National Drug Code (NDC) (11 Digits)	
Medication Name:		Medication Name:	
Medication Strength:		Medication Strength:	
Physician Name:		Physician Name:	
Physician NPI: (Obtain from Physician)		Physician NPI: (Obtain from Physician)	
Quantity/Day Supply:		Quantity/Day Supply:	
Patient Paid:		Patient Paid:	

Additional Medication		Additional Medication	
Pharmacy NABP: (Obtain from Pharmacy)		Pharmacy NABP: (Obtain from Pharmacy)	
Fill Date:		Fill Date:	
RX #:		RX #:	
National Drug Code (NDC) (11 Digits)		National Drug Code (NDC) (11 Digits)	
Medication Name:		Medication Name:	
Medication Strength:		Medication Strength:	
Physician Name:		Physician Name:	
Physician NPI: (Obtain from physician)		Physician NPI: (Obtain from physician)	
Quantity/Day Supply:		Quantity/Day Supply:	
Patient Paid:		Patient Paid:	

For additional medications, attach a separate page.

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INSTRUCTIONS

A. WHEN TO USE THIS FORM

1. This claim form is to be used only when it has been necessary to purchase prescriptions because your participating pharmacy did not honor your identification card or was unable to directly submit your claim. It should also be used when it was necessary to have your prescriptions filled at a non-participating pharmacy.
2. Submit this form to the address below as soon as you have your prescription(s) filled in order to receive prompt payment. IT IS NOT necessary to keep the form until completely filled.

B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form under **Cardholder Information.** Transfer the Cardholder Identification Number, Member Number (if applicable) and Group Number from your identification card.
2. A separate claim form must be completed for each **patient.**
3. Have your pharmacist complete the **PRESCRIPTION INFORMATION** section for each prescription filled and the **PHARMACY INFORMATION** section. If you are unable to have the form completed by your pharmacist, most of the information needed in these sections can be copied from the prescription label and/or your receipt.
4. **IMPORTANT:** The drug quantity, drug name and strength **or** eleven digit National Drug Code (NDC) is required and **must** appear on your submitted claim(s) or receipt(s).
5. **The original paid pharmacy receipt(s) must accompany this form. A cash register receipt is not satisfactory proof of purchase.**
6. **FOR COMPOUNDED PRESCRIPTIONS ONLY:** Ask your pharmacist for assistance. The NDC number appearing on the claim should be that of the most expensive prescription ingredient. Should you have more than one compounded prescription, please use additional claim forms.
7. Claim forms submitted without the required information can cause payment delays and result in the information being returned for completion.

C. WHERE TO MAIL THIS FORM

1. Mail this form and your original paid pharmacy receipt(s) to: Your Benefit Manager at your company or:

   MedImpact – DMR
   7835 Freedom Avenue NW
   North Canton, OH 44720

2. Or you can fax this form and your receipts to 866-646-1403 Attn: DMR Department.
3. Please allow up to four weeks for processing and payment of your claims. For Part D claims, please allow up to 14 days for processing and payment of your claims.
4. You may call 1-800-361-4542 between 8:00 AM and 9:00 PM (Eastern Time) for questions or problems concerning your submitted claims.

CLAIMS WITH MISSING OR ILLEGIBLE INFORMATION WILL BE RETURNED