

Medicare Part D Coordination of Benefits / Direct Claim Form

Empire Plan Medicare Rx



See the back for instructions. Complete all information. An incomplete form may delay your reimbursement. If you are not a Medicare Part D member and complete this form, it may delay the processing of your claim.

Member/Subscriber Information *See your prescription drug ID card.*

Group No.

Empire ID#

Medicare Rx ID#

Member Name (First, Last): _____

Street Address: _____

City: _____
State Zip

Date of Birth (MM/DD/YYYY)

Pharmacy Information

Name of Pharmacy: _____

Street Address: _____

City: _____
State Zip

Telephone (include area code)

National Provider ID Number: _____

Prescribing Physician Information

Physician Name: _____

Physician Address: _____

City: _____
State Zip

NPI/DEA/State License #: _____

Coordination of Benefits

(Another Health Plan has paid a portion)
Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?
 Yes No

- Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid
- Card Program
- Mail-order pharmacy/The **Medco Pharmacy**[®] (now a part of the Express Scripts family of pharmacies)

Acknowledgment

I certify that the medication described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

Signature of Member _____

Request for a True Out-of-Pocket (TrOOP) Update

This section is not required for a direct claim reimbursement. Please complete this section only if you have a request for a TrOOP update. (If you have a direct claim and this section is completed, your reimbursement will be delayed.)

1. Please include all applicable pharmacy receipts and/or Explanation of Benefits statements with this form.
2. Check off which of the payers below paid your claim.

A discount card A Patient Assistance Program (PAP) A secondary payer

3. Other Coverage Section:

Other Insurance Company Name: _____

Other Policy Number: _____

Other Policy Holder Name: _____

Date of Service	Drug Name – Rx Number	Charge	Amount Patient Paid	Amount Other Payer Paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

For compound prescriptions, you must complete the section to the right, and the pharmacy receipt must include the following:

- Name of each ingredient contained in the prescription.
- A valid NDC for each ingredient.
- For each NDC number, indicate cost per ingredient.
- The quantity of each ingredient (Note: If you need help getting this compound drug information, please contact your pharmacist.)

Rx #	Date filled	Quantity	Days' supply	Price
VALID 11-digit NDC #				
Total quantity				
Total charge				

Step-by-Step Instructions

- Complete all applicable sections on side 1.
- You must complete a separate claim form for each pharmacy used.
- Tape pharmacy receipts to an additional piece of paper; do not staple.
- You must submit claims no later than 36 months from the date of purchase.
- Read the acknowledgment at the bottom of side 1; sign and date the form.

Return the completed form and applicable receipt(s) to:

Empire Plan Medicare RX
P.O. Box 5200
Kingston, NY 12402-5200

For standard prescriptions, the pharmacy receipt must include:

- Date prescription filled
- DAW (Dispense As Written)
- Pharmacy name and address
- Doctor name and ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- Amount paid

Other Coverage Paid: You must first submit the claim to the primary insurance carrier. Once the Explanation of Benefits (EOB) from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipt(s) on a blank sheet of paper, and enclose the EOB from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription Drug Programs or HMO Plans Card Program: If the primary plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no EOB is needed. Just complete this form and tape the prescription receipt(s) on a blank sheet of paper that shows the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

The Medco Pharmacy: If the primary plan is the **Medco Pharmacy**, complete this form and include either the prescription receipt(s) that show(s) the co-payment or coinsurance amount paid to the mail-order pharmacy, or the statement of benefits you receive from the mail-order pharmacy.

If you have questions about how to complete this form, you may call toll-free at 1-877-7-NYSHIP (1-877-769-7447).

Visit us online anytime at
<https://www.cs.ny.gov/empireplanmedicarerx>

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