Medicare Part D Prescription Drug Reimbursement Form

This form can be sent via mail, email or fax:

Mail: PO Box 52077
Phoenix, Arizona 85072-2077

Email: RxPaperClaim_AnthemMEDD@CVSHealth.com **Fax:** (401)-652-1911

Cardholder Information

Cardholder ID #____________________

Cardholder Name (*Last, First MI.*)____

Date of Birth______________ Street Address______________________________________

____________________ City_____________________________ State_______ Zip____________________

Other Prescription Drug Coverage

1. Is the patient eligible for primary prescription drug coverage from another insurance company? □ Yes □ No

2. If yes, did the patient submit the claim to this other insurance company? *(If yes, include the Explanation of Benefits from the other insurance company.)* □ Yes □ No

3. Did the other insurance company pay as the primary insurer? □ Yes □ No

Pharmacy Information

Pharmacy Name____ Pharmacy NPI____________________

Address____ Phone ______________________

City____ State_________ Zip___________________

Physician Information

Name____ Physician NPI ___________________

Physician Address____

Phone ____________________ City_________________________ State_____ Zip ________________

HealthSun 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 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500).

Prescription Detail

Date of Service ______________________ Rx #_____________________NDC ______________________
Drug Name____ Qty_________ Day Supply ____
Drug Cost ______________

1. Is this a compound Rx? ☐ Yes ☐ No
2. Was this prescription filled in a foreign country? ☐ Yes ☐ No

Compound Prescriptions Only *(if covered)*			
11-digit NDC Number	Ingredient Name	Quantity	Ingredient Cost
		Total Paid by Cardholder	

Medicare Part D Vaccine Claim Only *(If covered)*	Admin Fee________ Total Paid by Cardholder ______

Requestor's Signature

Signature____ Date _____________

HealthSun 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 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500).