# Medicare Part D Prescription Drug Reimbursement Form

This form may be sent to us by mail or fax:
Address: 3250 Mary Street Suite 400
Coconut Grove, Florida 33133
Attention: Part D Department

Fax Number: (305)-643-4323

You may also ask us for a Reimbursement coverage determination by phone (305)460-3901

## 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). HealthSun Health Plans is an HMO plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal.

## 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________<br>Total Paid by Cardholder_______ |
|---|---|

## Requestor's Signature

Signature_____________________________________________________ Date _____________

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