



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). 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 _____
Total Paid by Cardholder _____

Requestor's Signature

Signature _____ Date _____