# Prescription drug reimbursement claim form

(ConnectiCare, inc. and ConnectiCare of Massachusetts, inc.)

| Cardholder's Name (Last, First, MI): | Date of Birth: | Gender: ☐ M ☐ F | Cardholder ID Number: |
|---|---|---|---|

☐ Check if new address

Address: Street ______________________

City/State ______________ Zip Code ____________ Daytime Telephone* (_____)____________

| Employer | Group Number |
|---|---|

**PLEASE SIGN AND DATE HERE:** I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor. Any person who, knowingly and with intent to defraud ConnectiCare, Inc. or its members, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, is guilty of committing a fraudulent insurance act, which is a crime punishable in accordance with applicable law.

**Cardholder's Signature ▶** ______________________ **Date** ____________

| 1 | Patient's Name | Relationship to cardholder ☐ Self ☐ Spouse ☐ Dependent | Gender: ☐ M ☐ F | Date of Birth: | Total number of receipts attached: |
|---|---|---|---|---|---|
| Pharmacy Name and Address: | | | Physician Name (name of prescribing doctor) and NPI# | | |

| 2 | Patient's Name | Relationship to cardholder ☐ Self ☐ Spouse ☐ Dependent | Gender: ☐ M ☐ F | Date of Birth: | Total number of receipts attached: |
|---|---|---|---|---|---|
| Pharmacy Name and Address: | | | Physician Name (name of prescribing doctor) and NPI# | | |

| 3 | Patient's Name | Relationship to cardholder ☐ Self ☐ Spouse ☐ Dependent | Gender: ☐ M ☐ F | Date of Birth: | Total number of receipts attached: |
|---|---|---|---|---|---|
| Pharmacy Name and Address: | | | Physician Name (name of prescribing doctor) and NPI# | | |

Does the patient reside in an **assisted living facility?** ☐ yes ☐ no | Is this claim for **allergy serum?** ☐ yes ☐ no

Does the patient have primary prescription drug coverage through another insurance carrier? ☐ yes ☐ no

Did the patient submit this claim to the other carrier? ☐ yes ☐ no *If yes, please attach an explanation of benefits from your primary carrier.*

PRESCRIPTION INFORMATION

**IMPORTANT** All prescription claims must have prescription receipts/labels which include:

▪ Pharmacy Name/Address ▪ Date Filled ▪ Drug Name, Strength and NDC ▪ Rx Number ▪ Quantity ▪ Days Supply ▪ Price ▪ Patient's Name

***Claims received missing any of the above information may be returned or payment may be denied or delayed***

☐ Please tape receipts to separate piece of paper.

☐ Patient history print outs from the pharmacy are also acceptable but MUST be signed by the Pharmacist.

☐ CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.

Reason for claim submission or special notes:

*I understand that the phone numbers I provided on this application may be used by ConnectiCare or any of its contracted parties to contact me about my account, the provision of services to me or my health benefit plan or related programs.

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RXCLAIM 1220

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## PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE FORM ON REVERSE SIDE.

### Cardholder's Information

1. Print Cardholder's name (last, first, middle initial).
2. Print Cardholder's date of birth.
3. Circle the correct letter to indicate if Cardholder is male or female.
4. Print Cardholder's ID number (found on your ConnectiCare card).
5. Print Cardholder's mailing address and telephone numbers. Check box if this is a new address.
6. Indicate Cardholder's employer (if applicable), and group number (found on your ConnectiCare card).

**IMPORTANT: CLAIM FORM MUST BE SIGNED.**
**UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED.**

### Patient Information

1. Print Patient's name.
2. Identify relationship to cardholder, gender, date of birth, and number of prescriptions submitted for each patient.
3. Print Pharmacy name and address and the prescribing Doctor and NPI number used by each patient.

### Specific Claim Information

Answer each question by checking correct box. Use the space provided for special notes if necessary.

### Prescription Information

Each submission must include prescription receipts/labels **or** a patient history printout from your pharmacy, **signed** by the dispensing pharmacist, which include all information listed below:

- Pharmacy name and address
- Quantity
- Date filled
- Days Supply
- Drug name, strength and NDC number
- Price
- Rx Number
- Patient name

Please note that claims received that are missing any of the above information may be denied. It is preferable to have receipts unattached or taped to a separate piece of paper. Please do not staple or glue.

### Please return this claim to:

Express Scripts
ATTN: Commercial claims
P.O. Box. 14711
Lexington, KY 40512-4711
Fax: 1-608-741-5475

### Questions?

Call ConnectiCare Member Services at 1-800-251-7722

# Language & Non-Discrimination Notice

ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06032, Phone: 1-800-251-7722, and TTY: 711. You can file a grievance in person or by mail. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-251-7722 (TTY: 711）。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 (ATS: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-251-7722 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-251-7722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-7722 (TTY: 711)번으로 전화해 주십시오.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-251-7722 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-251-7722 (TTY: 711) पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-251-7722 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-251-7722 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-251-7722 (TTY: 711)។

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-251-7722 (TTY: 711).