MERCYCARE HEALTH PLANS

# Prescription Drug Claim Form

Compound Claim

## Part 1: Member Information

1. Complete ALL information. Your ID Number can be located on your member ID card.
2. Submit claims within the filing period specified by your Benefit plan. For questions about your filing period please review your Member handbook or call the Customer Care number on your member ID card.
3. Please submit a separate form for each patient for which you purchased medications.
4. Reimbursement will be made directly to the CARDHOLDER unless otherwise noted.

| First Name | Last Name | MI |
|---|---|---|
| Telephone Number<br>(  ) | Date of Birth | Gender (Circle One)<br>Male Female |
| ID Number | Subscriber's Employer (PCN) | |
| Mailing Address | | |
| City | State | ZIP Code |
| Member Signature | | Date Signed |

## Part 2: Pharmacy Information

1. Complete ALL information.
2. Please submit a separate form for each pharmacy from which you purchased medications.

| Name | | |
|---|---|---|
| Street Address | | |
| City | State | ZIP Code |
| Pharmacy National Provider Number | | Telephone Number<br>(  ) |
| Pharmacist Signature | | |

For Reimbursement of Compound Drug Preparation, see the table below.
Please indicate the time spent preparing the compound drug in the Receipt Information on page 2.

| Time | Reimbursement |
|---|---|
| 1 – 5 minutes | $10.00 |
| 6 – 15 minutes | $15.00 |
| 16 – 30 minutes | $20.00 |
| 31+ minutes | $25.00 |

**Part 3: Receipt Information**

1. Include original pharmacy receipt(s) or pharmacy printout(s); Cash Register Receipt(s) without pharmacy detail will not be accepted. Tape original pharmacy receipt(s) to additional page and submit with claim form. *Please* DO NOT staple.
    a. Compound medications must have at least 2 ingredients, and at least 1 ingredient must be a Federal legend drug.
    b. All active ingredients must be covered as part of your formulary and all script information must be submitted.
2. Receipt(s) must contain the information outlined under Part 3. If your receipt(s) are missing any of this information, please have your pharmacist fill in the missing information.
3. Please provide the explanation of benefits (EOB) or denial letter from the primary insurance carrier if you have primary coverage with another insurance carrier.
4. An incomplete form may be denied, delayed or returned.
5. Receipts will not be returned, remember to keep a copy of the completed claim form and receipt(s) for your records.

| | | |
|---|---|---|
| Rx Written Date | Date Rx Filled | Diagnosis Code and Description |
| Rx Number | Final Form of Compound (cream, patches, suppository, suspension, etc.) | |
| Day Supply | Total Volume (Grams, ml, etc.) | |
| Prescribing Physician First/Last Name | | Prescribing Physician NPI |
| Original Cost of Rx | Amount Primary Insurance Paid on Rx | Member Paid Amount |

**Compound Ingredients**

| | Ingredient Name | Ingredient NDC | Metric Decimal Quantity | AWP/WAC |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |

| | |
|---|---|
| Total Ingredient Cost | |
| Preparation Time | |
| Member Copay | |

| **Reimburse** (Circle One) | |
|---|---|
| Pharmacy | Member |

**Mail this form along with receipts to:**
Navitus Health Solutions, LLC
P.O. Box 999
Appleton, WI 54912-0999
OR
Fax this form along with receipt(s) to:
(920)735-5315 / Toll Free (855)668-8550