Prescription Drug Reimbursement Instructions

Thank you for choosing ATRIO Health Plans for your prescription drug coverage. Use the attached claim form(s) for any prescription drug reimbursement requests you may have. Please read the attached form(s) carefully. Retain copies of receipts for your records. Receipts will not be returned.

Manual submission of claims does not guarantee reimbursement. If the prescription drug(s) is non-formulary or has Prior Authorization, Step Therapy, or Quantity Limits requirements or is restricted in some other way, we will make a Coverage Determination according to our Coverage Determination and Exceptions process. **Requests that require a Coverage Determination should be submitted to your local ATRIO office location at one of the addresses listed below.**

Once we have received the completed claim form with receipts, if approved, we will mail our determination with a check (if applicable) to you within 14 days.

All other requests can be submitted as listed on the attached Medicare Part D Prescription Drug Claim Form. Please indicate the reason for requesting reimbursement on the attached form.

Please note: If the reason is due to Coordination of Benefits, claims must be submitted with pharmacy receipt(s) identifying copays paid and an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary insurance payment).

Please submit completed form(s) and pharmacy receipts in one of the following ways:

Hand Deliver to:	
ATRIO Health Plans 13190 SW 68th Parkway, Suite 100 Tigard, OR 97223	ATRIO Health Plans 2270 NW Aviation Drive, Suite 3 Roseburg, OR 97470
ATRIO Health Plans 550 Hawthorne Ave SE, Suite 140, Salem, OR 97301	**Office hours:** Monday – Friday, 8 a.m. to 5 p.m. local time.
Customer Service - 1-877-672-8620 (TTY 711)	**Email:** CustomerService@atriohp.com
Mail or Fax Directly to:	
MedImpact Healthcare System, Inc. PO Box 509108 San Diego, CA 92150-9180	**Fax:** 541-672-8670 **Attention:** Atrio Pharmacy Department DMR **Email:** pharmacy@atriohp.com **Subject**: DMR Request (Member)

Medicare Part D Prescription Drugs Claim Form

Claim Form Instructions

Please read carefully before completing this form. **Claim forms that do not include the required information may delay or inhibit our ability to process your request for reimbursement. Completion and submission of this form does not guarantee reimbursement. Claims are subject to limitations, exclusions, and other provisions of your benefit plan.**

Part 1: Member Information (to be completed by the member)

1. Complete all information under Part 1. The member/cardholder ID Number is located on your insurance card.
2. Submit claims within the filing period specified by your health plan. For questions about your filing period, please call the number on the back of your insurance card.
3. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.
4. **IMPORTANT NOTE: Payment and related correspondence will be sent to the primary subscriber unless you provide us with an Alternate Address in Part 1.**

Part 2: Receipt

1. Submit prescription receipts/labels that contain the requested information (shown below) or have your pharmacist complete Part 2 and Part 3. If you do not receive a receipt for your prescription(s), pharmacist signature is required.
2. Include all original pharmacy receipt(s). Tape receipts to a separate page to be submitted with the claim form. Note: Please do not staple receipts or other documentation to the claim form.
3. For multiple claims, please use the multiple prescription form.

PRESCRIPTION/PHARMACY INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information. Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234 (509)555-1234
123 Any Street **Store NPI: 1234567890**
Home Town, US 12345-6789

RX 1234567 **Date Filled: 1/1/2009**

DOE, JANE DOB:
01/01/1900
456 Home Road (509)555-5678
Home Town, US 12345

Amoxicillin 500 mg capsules (Teva) **DAW: 0**
00000-1111-22 **QTY: 45** **Days Supply: 30**

A. SMITH, MD
NPI: 4567890123

U&C: 200.00 **COPAY: 20.00**

1. Date Filled*
2. RX Number
3. Quantity*
4. Day Supply*
5. National Drug Code (NDC)*
6. Medication Name and Strength*
7. Physician Name
8. Physician National Provider ID (NPI)
9. DAW
10. Usual and Customary Price (U&C)/RX Price*
11. Copay*
12. Pharmacy National Provider ID (NPI)

***** *Denotes information required to process a claim. If this information is not included, it may delay or inhibit our ability to process your request for reimbursement.*

4. Remember to keep a copy of the completed claim form and receipt(s) for your records.
5. Send the completed form and receipt(s) to:

Atrio Health Plan office in your area
-or-
Fax: 541-672-8670
E-mail: Pharmacy@atriohp.com

Medicare Part D Prescription Drugs Claim

PART 1

*Indicates requiredinformation

Primary Subscriber/Cardholder ID Number*	Group Number	
Name of Health Plan/Insurance	Primary Subscriber Name*	DOB: (mm/dd/yyyy)* / /
Member Name: (First, Middle, Last)*	Date of Birth: (mm/dd/yyyy)* / /	Relationship to Primary Subscriber Self ☐ Spouse ☐ Dependent ☐
Primary Subscriber Address: (Street, City, State, Zip code)		
Alternate Address: (Street, City, State, Zip code) ***If no alternate address is specified, correspondence and/or payment will be forwarded to the primary subscriber address on file with your health plan/insurance.**		
Member Telephone Number: ( )		

Indicate reason for manually filing these claims (select one):

- ☐ Coordination of Benefits – Claims must be submitted with pharmacy receipt(s) identifying copays paid ***and*** an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary insurance payment)
- ☐ Discount Card was used
- ☐ Health plan/insurance information or insurance card not available at the time of purchase
- ☐ Pharmacy not participating in network
- ☐ Pharmacy unable to process claim electronically
- ☐ Emergency – If Emergency, describe emergency below

Manual submission of claims does not guarantee reimbursement.

Describe Emergency:

PART 2

RX Number	Date Filled*	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*	
	/ /					
Medication Name and Strength *		Physician Name & NPI Number Name:_____ NPI : _____			RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

PART 3

Affix Pharmacy Label Here or Enter the Required Information:

Pharmacy Name*			Pharmacy Telephone Number	
Street Address			NPI*	
City	State	Zip	Pharmacist Signature*	Date*

By signing below, I certify that I have read and understood this form, and that the information provided on this form is true and correct to the best of my knowledge.

_____ Member or Authorized Representative Signature*

_____ Date*

NOTE: If this form is completed and signed by an Authorized Representative, an Authorization of Representation (AOR) must accompany this form.

Medicare Part D Prescription Drug Claim Form

Multiple Prescription Claim Form

* Indicates requiredinformation

RX Number	Date Filled*	New ☐ Refill ☐	Quantity*	Day Supply*	National Drug Code (11 Digit)*
	/ /	(checkone)			
Medication Name and Strength *			Physician Name & NPI Number Name NPI	RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled*	New ☐ Refill ☐	Quantity*	Day Supply*	National Drug Code (11 Digit)*
	/ /	(check			
Medication Name and Strength *			Physician Name & NPI Number Name NPI	RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled*	New ☐ Refill ☐	Quantity*	Day Supply*	National Drug Code (11 Digit)*
	/ /	(checkone)			
Medication Name and Strength *			Physician Name & NPI Number Name NPI	RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled*	New ☐ Refill ☐	Quantity*	Day Supply*	National Drug Code (11 Digit)*
	/ /	(checkone)			
Medication Name and Strength *			Physician Name & NPI Number Name NPI	RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled*	New ☐ Refill ☐	Quantity*	Day Supply*	National Drug Code (11 Digit)*
	/ /	(checkone)			
Medication Name and Strength *			Physician Name & NPI Number Name NPI	RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled*	New ☐ Refill ☐	Quantity*	Day Supply*	National Drug Code (11 Digit)*
	/ /	(checkone)			
Medication Name and Strength *			Physician Name & NPI Number Name NPI	RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled*	New ☐ Refill ☐	Quantity*	Day Supply*	National Drug Code (11 Digit)*
	/ /	(checkone)			

Medication Name and Strength *	Physician Name & NPI Number Name NPI	RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled* / /	New Refill (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*
Medication Name and Strength *		Physician Name & NPI Number Name NPI		RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

Medicare Part D Prescription Drugs Claim

COMPOUND PRESCRIPTIONS

The pharmacy or dispensing facility must complete the remaining portion of this form and return it to the member/patient or provide the member/patient with a Universal Claim Form for a Compounded Medication.*

- ☐ Provide an 11-digit NDC number for each of the ingredient(s) in the medication
- ☐ Indicate the drug ingredient(s) and quantity.
- ☐ Indicate the metric quantity dispensed in number of tablets, grams or milliliters for liquids, creams, ointments or injectables.
- ☐ Indicate the amount paid for the prescription by the patient.

Compound Prescriptions

For pharmacy use only*

Total Charge:			**$**

Note: If the medication/drug was purchased in a foreign country,

the currency must be converted into US dollars.

The original pharmacy prescription label or cash receipt should accompany this claim form or the Universal Claim Form for a compounded medication. Prescription labels and receipts will not be returned; you may wish to make copies for your records.

Medicare Part D Prescription Drugs Claim

IMPORTANT CLAIM NOTICE

AL, AK, AZ, CT, DE, GA, ID, IL, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OR, RI, SC, SD, VT, WI, WY Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties. **Additionally, DE, ID, MN, NM, OH Residents**: Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or criminal penalties.

AR, CA, DC, FL, HI, MD, ME, OK, TN, TX, UT, VA, WA, WV Residents: WARNING – *For your*

protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information is guilty of a crime and may be subject to imprisonment, fines, and/or denial of insurance benefits. **Additionally, AR, CA, FL, MD, OK, TX, UT, WV Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or confinement in prison.

CO Residents: WARNING – For your protection, state law requires the following statement to appear on this form. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department or regulatory agencies.

NY Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PA Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.

Puerto Rico Residents: WARNING – For your protection, we are required to print the following. Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefits, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollar ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.