MEMBER REIMBURSEMENT - PHARMACY CLAIM FORM

(**For Pharmacy claims only** - please complete one form per provider, per date of service)

FHCP Medicare

Instructions

1. To request reimbursement, please submit the following to the address listed at the bottom of this form within **12 months** of the date of service. Extensions may be granted based on circumstances. Any missing information may result in delay or denial of the request.
   (a) This completed and signed reimbursement form or a written request for reimbursement with all necessary information, (b) Proof of services rendered, and (c) Proof of payment for the services being rendered.
2. You may need your pharmacy provider to assist and supply information in completing this form. Refer to FAQs on page two for additional information.
3. Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services that were rendered outside of the United States may take longer.
4. Reimbursement payment will be sent to the patient at the address FHCP has on record.
5. Retain a copy of all receipts and documentation for your records.

Patient Information

FHCP ID	Last Name	First Name	Middle Initial
Date of Birth	Telephone Number	Email Address	
Mailing Address			

Prescription Information

Dispensing Pharmacy Name	Telephone Number	Fax Number
Dispensing Pharmacy Address		
If services were received outside of the United States, please provide information regarding country, documentation language, and currency		
Detailed explanation of illness/injury and/or circumstances resulting in use of non-participating pharmacy		

The original pharmacy receipt for each medication (not the register receipt) must be submitted with this request for reimbursement and must contain the information noted below. If you do not have pharmacy receipts, ask your pharmacy to provide them to you.

● Patient Name ● Date prescription filled ● National Drug Code (NDC) number ● Prescription number (Rx number) ● Name and address of pharmacy ● Name of drug and strength ● Quantity ● Prescribing physician name or ID number

Drug Name	Fill Date	Amount Paid
	Total Amount Paid	$ 0.00

I attest that the above information is true and accurate and that the medications were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled, and I may be subject to criminal and/or civil penalties for false health care claims. I understand that reimbursement payment will be made to the Member and will contain information about the service (e.g., provider name, date, description of service). I also understand that FHCP may request any additional information it deems necessary to process the claim.

Patient (or guardian / representative) Printed Name _____ Signature _____ Date _____

Checklist

- ☐ I have completed and signed this form in its entirety.
- ☐ I have enclosed Pharmacy Receipts as Proof of Prescriptions Received
- ☐ I have enclosed documents of Payment of Services received

Please submit this form and all documentation to:
FHCP Medical Claims Department – Member Reimbursement
P.O. Box 10348
Daytona Beach, FL 32120-0348
or via Email to Claims@FHCP.com

Member Reimbursement Pharmacy Claim Form FAQs

Question	Answer
What is this form used for?	Member Reimbursement Pharmacy Claim Forms should be submitted in circumstances when you have been required to pay for medications from a non-contracted, out-of-network, or out-of-area provider related to urgent/emergent care. *You don't have to use this form, but it will help us process the information faster. If you do not use the form, ensure you submit with your request the original pharmacy receipt for each medication (not the register receipt) which must contain the information noted below. If you do not have pharmacy receipts, ask your pharmacy to provide them to you.* ● Patient Name ● Date prescription filled ● National Drug Code (NDC) number ● Prescription number (Rx number) ● Name and address of pharmacy ● Name of drug and strength ● Quantity ● Prescribing physician name or ID number
What is my responsibility?	Cost share, such as copayments, deductibles, and/or coinsurance, and non-covered services, will be member responsibility. Actual payment for covered prescriptions will be paid at the appropriate level according to your plan benefits.
What if my service was completed out of the service area?	Please note that submission for reimbursement does not guarantee payment. Only covered prescriptions deemed medically necessary will be considered for reimbursement. Refer to your Evidence of Coverage for limitations, exclusions, and requirements for prior authorization or referral.
Who should I contact if I need help with completing this form?	If you were temporarily out of the service area and had a medical emergency, be sure to report your emergency to us as soon as possible. Copayments, deductibles, coinsurance, and non-covered services will be patient responsibility. Routine care is not covered outside the service area and will not be reimbursed unless you have prior authorization from FHCP and/or services are eligible under the FHCP Medicare Rx Plus POS plan. Contact the dispensing pharmacy for provider or claim specific information. If you need assistance in completing this form not related to provider or specific claim information, please contact Claims Customer Service at 386-615-5010.

Field Name	Description / Information
FHCP ID	(6) digit Member ID with (3) letter prefix, found on the front of the FHCP ID Card
Detailed explanation of illness / injury	Provide a detailed description of illness or injury (e.g., flu, broken leg, manic-depressive disorder, asthma), including relevant dates / locations
Drug Name	Name of Drug (e.g. amoxicillin, Lexapro, atorvastatin, etc.)
Strength	The amount of drug in the dosage form or a unit of the dosage form (e.g. 500 mg capsule, 250 mg/5 mL suspension)
NDC Number	National Drug Code- a unique 10-digit, 3-segment number (e.g. 012345-6789-00)
Date Filled	The date the prescription was filled by the pharmacy.
QTY	The quantity of the medication provided. (e.g. 30, 1500 ml, etc.)
# of Days Supply	The number of days of medication provided. (e.g. 5 days, 30 days, etc.)
Amount Paid	Amount paid for each prescription and the total requested reimbursement amount.
Pharmacy Receipt for Proof of Prescription(s) Received	Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information noted below. If you do not have pharmacy receipts, ask your pharmacy to provide them to you. ● Patient Name ● Date prescription filled ● National Drug Code (NDC) number ● Prescription number (Rx number) ● Name and address of pharmacy ● Name of drug and strength ● Quantity ● Prescribing physician name or ID number
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: The front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and amount paid.

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