

CLAIM FORM INSTRUCTIONS

Part 1: Member Information

- Complete all information under Part 1. Your CarePlus ID Number is on your member ID card.

Part 2: Receipt and Prescription Drug Information

- Include all original pharmacy receipts and patient package insert(s) if applicable. Cash register receipts are not sufficient. Tape receipt(s) and patient package insert(s) to a separate page and submit with claim form. If medication was provided in ER or doctor's office, provide itemized statement.
- Receipt(s) must contain the information outlined under Part 2 of the claim form below.

Part 3: Pharmacy Information

- Provide information about the pharmacy or doctor's office where medications were obtained.
- Please submit a separate form for each pharmacy from which you purchase medications.

Part 4: Description of Issue

- Provide information about the reason of your request.

Note: Prescriptions that are filled by pharmacies outside the United States and its territories are not covered; e.g., cruise ships.

If your receipt(s) and insert(s) are missing any of the required information, please ask your pharmacy or doctor's office to provide it. Remember to keep a copy of the completed claim form and receipt(s) for your records.

If you have any questions, please call Member Services at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays, and we will return your call within one business day.

Once all sections have been filled in, please sign and date. Your signature attests that all information is accurately represented by the completed form and accompanying documents.

Mail the completed form, receipt(s), and patient package insert(s) to:

CarePlus Health Plans
Attention: Member Services Department
PO Box 277810
Miramar, FL 33027

PART 1: MEMBER INFORMATION

CarePlus ID Number	Date of Birth (mm/dd/yyyy)	Medicare ID Number
Member Last Name	First Name	MI
Gender	Person Completing This Form	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	
Member Street Address		
City	State	ZIP Code
Member Telephone		

Patient Residence:	
<input type="checkbox"/>	Home
<input type="checkbox"/>	Nursing Home
<input type="checkbox"/>	Assisted Living
<input type="checkbox"/>	Group Home
<input type="checkbox"/>	Intermediate Care
<input type="checkbox"/>	Hospice

PART 2: RECEIPT AND PRESCRIPTION DRUG INFORMATION

Ensure your receipt includes the following information:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Date Filled | <input type="checkbox"/> Quantity | <input type="checkbox"/> Dosage Form | <input type="checkbox"/> Physician Name |
| <input type="checkbox"/> Medication Name | <input type="checkbox"/> Days Supply | <input type="checkbox"/> Rx Number | <input type="checkbox"/> Physician ID (NPI or DEA#) |
| <input type="checkbox"/> Medication Strength | <input type="checkbox"/> Rx Price (including tax) | <input type="checkbox"/> National Drug Code (NDC)* | |

*In case of compound(s), NDCs for every ingredient are listed.

Dispense as Written (DAW): This code is a message from your doctor to the pharmacist about using generics. If it applies to your prescription, it can be found on your pharmacy label or your pharmacy can provide it.

- DAW: ☐ 0 – Not Applicable ☐ 1 – Doctor mandates that brand product be dispensed
☐ 2 – Patient mandates that brand product be dispensed ☐ 5 – Brand submitted as generic
☐ 7 – Brand mandated by state law

Is this a compound medication? ☐ Yes ☐ No If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No
 \$_____

If yes: Vaccine Cost: \$_____ Admin Fee:

National Drug Code (NDC)	Drug Name	Total Cost	Fill Date (mm/dd/yyyy)	Rx Number
--------------------------	-----------	------------	------------------------	-----------

Dispense as Written Code (if applicable)	Quantity	Day Supply	Dosage Form Strength
--	----------	------------	----------------------

Is this a compound medication? ☐ Yes ☐ No If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No
 \$_____

If yes: Vaccine Cost: \$_____ Admin Fee:

National Drug Code (NDC)	Drug Name	Total Cost	Fill Date (mm/dd/yyyy)	Rx Number
--------------------------	-----------	------------	------------------------	-----------

Dispense as Written Code (if applicable)	Quantity	Day Supply	Dosage Form Strength
--	----------	------------	----------------------

Is this a compound medication? ☐ Yes ☐ No If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No
 \$_____

If yes: Vaccine Cost: \$_____ Admin Fee:

National Drug Code (NDC)	Drug Name	Total Cost	Fill Date (mm/dd/yyyy)	Rx Number
--------------------------	-----------	------------	------------------------	-----------

Dispense as Written Code (if applicable)	Quantity	Day Supply	Dosage Form Strength
--	----------	------------	----------------------

Is this a compound medication? ☐ Yes ☐ No If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No If yes: Vaccine Cost: \$_____ Admin Fee: \$_____

National Drug Code (NDC) Drug Name Total Cost Fill Date (mm/dd/yyyy) Rx Number

Dispense as Written Code (if applicable) Quantity Day Supply Dosage Form Strength

Is this a compound medication? ☐ Yes ☐ No If yes, please attach compound form from pharmacy if available

Was this prescription filled outside the US? ☐ Yes ☐ No

Is this a vaccine? ☐ Yes ☐ No If yes: Vaccine Cost: \$_____ Admin Fee: \$_____

National Drug Code (NDC) Drug Name Total Cost Fill Date (mm/dd/yyyy) Rx Number

Dispense as Written Code (if applicable) Quantity Day Supply Dosage Form Strength

PART 3: PHARMACY INFORMATION

Pharmacy Name Pharmacy ID (NCPDP or NPI#)

Pharmacy Street Address

City State ZIP Code Pharmacy Telephone

Pharmacy Service Type: ☐ Retail ☐ Compounding ☐ Home Infusion ☐ Institutional ☐ Mail Order
☐ Long Term Care ☐ Managed Care Organization ☐ Specialty ☐ Other

Physician Information

Physician Name Physician NCPDP or NPI

Street Address

City State ZIP Code Phone Number

PART 4: DESCRIPTION OF ISSUE

- ☐ Pharmacy will not accept my CarePlus plan
- ☐ Pharmacy was unable to process my claim electronically
- ☐ I did not have my plan information at the time of purchase
- ☐ I was charged for medications received during an Emergency Room visit
- ☐ I believe the claim was paid incorrectly
- ☐ I received a medication while on a cruise (Cruise itinerary must be included with request)

- ☐ I was administered a Part D covered vaccine in my doctor's office
- ☐ I filled my medication during a natural disaster or state of emergency
- ☐ I have drug coverage with a plan in addition to CarePlus (Coordination of Benefits):

Name of Insurance Co.: _____

Insurance Co. Phone: _____

Employer Name: _____

Member ID: _____

Please explain the issue:

IMPORTANT CLAIM NOTICE

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person:
 (1) files an application for insurance or statement of claim containing any materially false information; or
 (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act.

Member Signature _____ Date _____

NOTE: If this form is signed by anyone other than the member, additional documentation is required authorizing that representative. This may include an Appointment of Representative (AOR) form or statement, a Power of Attorney (POA), or other legal documentation. An AOR form is available at <https://www.careplushealthplans.com/Resources> for your convenience.

Important: At CarePlus, it is important you are treated fairly. CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities. The following department has been designated to handle inquiries regarding CarePlus' non-discrimination policies: Member Services, PO Box 277810, Miramar, FL 33027, 1-800-794-5907 (TTY: 711). Auxiliary aids and services, free of charge, are available to you. 1-800-794-5907 (TTY: 711). CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our Member Services number at 1-800-794-5907. Hours of operation: October 1 - March 31, 7 days a week, 8 a.m. to 8 p.m. April 1 - September 30, Monday - Friday, 8 a.m. to 8 p.m. You may leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.

Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.