UPMC *for Life*
UPMC Health Plan Medicare Program

PRESCRIPTION DRUG CLAIM FORM MEDICARE PART D

Patient Name (Last, First, MI)	Date of Birth	Gender M F	Patient ID Number

☐ Check if new address
Address

_____

City _____ State _____ ZIP Code _____ Phone _____

Plan Name (Plan Type)	Group Number

• Is Medicare Part D the patient's primary coverage? ☐Yes ☐No
• Does the patient have primary coverage under another plan, with Medicare considered secondary?
☐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 that include:
• Pharmacy Name/Address • Drug Name, Strength, and NDC • Days Supply • Script Number
• Patient Name • Date Filled • Price • Quantity
Please note: The above claim detail information is necessary in order to process your claim request.
• **Please tape receipts to a separate piece of paper.**
• **CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS**
(with the exception of diabetic supplies). **Number of receipts attached:** _____

• Is claim for **DIABETIC SUPPLY**? ☐Yes ☐No
If **Yes**, please ask your pharmacist which supplies are covered under your Part D plan. Please ensure receipts include:
• Pharmacy Name/Address • Type of Insulin and/or Type of Supply • Days Supply • Quantity
• Patient Name • Date Filled • Price
• Cash register receipts are acceptable but **pharmacist signature** is required if any information is handwritten.
• Is this claim for **allergy serum or vaccination**? ☐Yes ☐No
If **Yes**, please supply type or additional information: _____

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me. I have received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc., the company chosen by my plan sponsor to manage my pharmacy benefit, as well as my plan sponsor. Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim 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 subjects such person to criminal and civil penalties.

Patient Signature and Date _____

Please return this claim to:
UPMC Health Plan
Pharmacy Services Department
U.S. Steel Tower
600 Grant Street, 12th Floor
Pittsburgh, PA 15219

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

Patient Information

The patient is the insured member.

1. Print patient's name (Last, First, MI).
2. Print patient's date of birth.
3. Circle the correct letter to indicate if patient is male or female.
4. Print patient's ID number (found on prescription drug or health insurance card).
5. Print mailing address and phone number. Please check box if this is a new address.
6. Indicate Health Plan name and group number (refer to prescription drug or health insurance card) under which patient is covered.
7. Indicate if Medicare Part D is patient's primary insurance.
8. Indicate if patient has primary coverage under another plan. If patient has primary coverage under another plan, patient must submit claims with a copy of the Explanation of Benefits from the primary carrier.
9. **Please return this claim to:** **UPMC Health Plan**
   Pharmacy Services Department
   U.S. Steel Tower
   600 Grant Street, 12th Floor
   Pittsburgh, PA 15219

Prescription Information

1. Indicate number of receipts submitted for reimbursement consideration. In order to be processed, you will need to obtain prescription receipts or a patient history printout from your pharmacy that includes the following prescription detail:

   - Pharmacy Name and Address
   - Date Filled
   - Drug Name, Strength, and NDC Number
   - Quantity
   - Days Supply
   - Price
   - Patient Name
   - Script Number

   Please note: It is preferable to have receipts unattached or taped to a separate piece of paper. *Please* DO NOT staple.

2. Indicate if claim is for diabetic supply. If diabetic supply, please provide drug detail. Please note, only some diabetic supplies are covered under your Medicare Part D plan. Please seek assistance from your pharmacist for further guidance.
3. Indicate if claim is for allergy serum or vaccination and, if flagged as yes, please provide drug detail.

Questions? Your Health Care Concierge team is available toll-free at **1-877-539-3080.** TTY users should call **1-800-361-2629.** You can call us October 1 through February 14 seven days a week from 8 a.m. to 8 p.m. From February 15 through September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

All beneficiaries must use their plan sponsor's network pharmacies to access their prescription drug benefit, except under non-routine circumstances. Quantity limitations and restrictions may apply.

UPMC *for Life* has a contract with Medicare to provide HMO and PPO plans. Enrollment in UPMC *for Life* depends on contract renewal. UPMC *for Life* is a product of and operated by UPMC Health Plan Inc., UPMC Health Network Inc., and UPMC Health Benefits Inc. This document is available in alternate formats or languages.

Nondiscrimination Notice

UPMC Health Plan[1] complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression. UPMC Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression.

UPMC Health Plan[1]:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Civil Rights Administrator.

If you believe that UPMC Health Plan[1] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression, you can file a grievance with:

Civil Rights Administrator
UPMC Health Plan
600 Grant St., 55th Floor
Pittsburgh, PA 15219

Phone: 1-844-755-5611 (TTY: 1-800-361-2629)
Fax Number: 412-454-5964
Email: HealthPlanCompliance@upmc.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Administrator 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, 1-800-537-7697 (TDD).

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

[1]UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-539-3080 (TTY: 1-800-361-2629).

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 1-877-539-3080 (TTY：1-800-361-2629 ）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-539-3080 (TTY: 1-800-361-2629).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-539-3080 (телетайп: 1-800-361-2629).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-539-3080 (TTY: 1-800-361-2629).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-539-3080 (TTY: 1-800-361-2629) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-539-3080 (TTY: 1-800-361-2629).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-539-3080 (رقم هاتف الصم والبكم:1-800-361-2629).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-539-3080 (ATS: 1-800-361-2629).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-539-3080 (TTY: 1-800-361-2629).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-539-3080 (TTY: 1-800-361-2629).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-539-3080 (TTY: 1-800-361-2629).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-539-3080 (TTY: 1-800-361-2629).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-539-3080 (TTY: 1-800-361-2629)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-539-3080 (TTY: 1-800-361-2629).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-539-3080 (TTY: 1-800-361-2629).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-877-539-3080（TTY: 1-800-361-2629）まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-539-3080 (TTY: 1-800-361-2629).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-539-3080 (телетайп: 1-800-361-2629).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-539-3080 (TTY: 1-800-361-2629).

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