Medicare Part D Prescription Drug Reimbursement Form

This form may be sent to us by mail or fax:
Address: 3250 Mary Street
Coconut Grove, Florida 33133
Attention: Part D Department
Fax Number: (305)-643-4323

You may also ask us for additional information by phone (305)460-3901

Cardholder Information

Cardholder ID #_____

Cardholder Name (*Last, First MI.*)_____

Date of Birth_____ Street Address_____
_____ City_____ State_____ Zip_____

Other Prescription Drug Coverage

1. Is the patient eligible for primary prescription drug coverage from another insurance company? □ Yes □ No
2. If yes, did the patient submit the claim to this other insurance company? *(If yes, include the Explanation of Benefits from the other insurance company.)* □ Yes □ No
3. Did the other insurance company pay as the primary insurer? □ Yes □ No

Pharmacy Information

Pharmacy Name_____ Pharmacy NPI_____

Address_____ Phone _____

City_____ State_____ Zip_____

Physician Information

Name_____ Physician NPI _____

Physician Address_____

Phone _____ City_____ State_____ Zip _____

HealthSun complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500). HealthSun Health Plans is an HMO plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal.

Prescription Detail

Date of Service _____ Rx #_____NDC _____

Drug Name_____ Qty_____ Days Supply _____

Drug Cost _____

1. Is this a compound Rx? □ Yes □ No
2. Was this prescription filled in a foreign country? □ Yes □ No

Compound Prescriptions Only *(if covered)*

11-digit NDC Number	Ingredient Name	Quantity	Ingredient Cost
		Total Paid by Cardholder	

Medicare Part D Vaccine Claim Only *(if covered)*	Admin Fee_____ Total Paid by Cardholder_____

Requestor's Signature

Signature_____Date _____

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