Direct Member Reimbursement Form

MASS ADVANTAGE

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. Submit this form with the original prescription label receipt(s). Cash register and credit card receipts alone are not acceptable as proof of purchase. Reimbursement is not guaranteed. Claims will be subject to limitations, exclusions, and other provisions of the Plan Benefit.

Instructions

This form must be completely filled out to process your claim(s). Attach a copy of all prescription receipt(s) to the back of this form. Please submit **within 3 years** from the date the prescription was obtained. Prescription receipts should contain as much of the following information as possible:

1. Prescription number and date filled
2. Pharmacy name and telephone number
3. Drug name and strength
4. Quantity, day supply, and amount paid.

Contact Information

Please submit these items to Mass Advantage, Attn: MPD-1000UR, P.O. Box 64806, St. Paul, MN 55164-0811 or fax to 888-904-1139.

If you have any questions please contact Member Services — HMO: 1-844-918-0114, PPO: 1-844-915-0234 (TTY: 711); October 1 – March 31, 8 a.m. - 8 p.m. EST, 7 days a week and April 1 – September 30, 8 a.m. - 8 p.m. EST, Monday – Friday. Information is also available through our website at www.massadvantage.com.

1 Member Information

Member Name	Member ID

Address (include Suite #)

City	State	Zip

Phone Number	Email

2 You did not receive coverage at the pharmacy because (select at least one):

- ☐ You have not received your ID Card
- ☐ The pharmacy is not in the retail network
- ☐ The pharmacy cannot process the claim electronically
- ☐ It was an emergency - Please describe the emergency on a separate sheet
- ☐ The pharmacy or payer system was down
- ☐ You did not have your ID card and the pharmacy could not verify eligibility
- ☐ There were not any network pharmacies available where the prescription could be filled
- ☐ Other - Please describe on a separate sheet

3 Other Insurance Coverage Information

Are you eligible for primary prescription drug coverage from another insurance company? ☐ Yes ☐ No

Other Insurance Company's Name	Effective Date of Coverage

Member ID Number	Group Number

4 Prescription Information

	Rx Number	NDC Number	Compound Y/N	Date Filled (mm/dd/yyyy)	Quantity/Day Supply
1					

Drug Name/Strength	Amount Paid

	Rx Number	NDC Number	Compound Y/N	Date Filled (mm/dd/yyyy)	Quantity/Day Supply
2					

Drug Name/Strength	Amount Paid

	Rx Number	NDC Number	Compound Y/N	Date Filled (mm/dd/yyyy)	Quantity/Day Supply
3					

Drug Name/Strength	Amount Paid

	Rx Number	NDC Number	Compound Y/N	Date Filled (mm/dd/yyyy)	Quantity/Day Supply
4					

Drug Name/Strength	Amount Paid

5 Pharmacy Information

	Pharmacy Name	Pharmacy Phone Number	Pharmacy NPI Number
1			
2			
3			
4			

6 Prescriber Information

	Prescriber Name	NPI Number	Phone Number	State
1				
2				
3				
4				

REMINDER: To avoid having to submit a paper claim

- Always have your prescription drug card at the time of purchase
- Always use pharmacies in your network
- Use medication covered under your formulary

Signature

I certify that the patient for whom this claim is made is a covered person in this Prescription Drug Program and that the prescription is for the sole use of the named patient.

Member's/Subscriber's Signature _____ Date _____