Medicare Part D Prescription Drug Reimbursement Form

Cardholder Information

Cardholder ID ________________________ Cardholder Name ________________________________
Phone Number ________________________ Date of Birth _____________________________________
Mailing Street Address ________________ City _________________ State _______ Zip ________

Is the medicine covered under any other insurance? __ YES __ NO
If yes, is other coverage: __ PRIMARY __ SECONDARY
If other coverage is Primary, include the explanation of benefits (EOB) with this form.
Name of Insurance Company: ___________________ ID#: ________________________________

Pharmacy Information

Pharmacy Name_______________________________________ Pharmacy NPI ____________________
Pharmacy Address ____
Phone ___________________ City ________________________ State ____ Zip _______________

Physician Information

Name ____ Physician NPI ____________________
Physician Address ____
Phone ___________________ City ________________________ State ____ Zip _______________

Prescriptions

You MUST include all original pharmacy receipts in order for your claim to process.
Number of prescriptions are you submitting for reimbursement: ______________________

Prescription (Rx) Number ______________
Drug Name ________________________ National Drug Code (NDC Number) ______________________
Date Filled (MM/DD/YY) _________________ Total Paid ($ Amount) ____________________________
Quantity of Drug ________________________ Days' Supply ___________________________________

Prescription (Rx) Number ______________
Drug Name ________________________ National Drug Code (NDC Number) ______________________
Date Filled (MM/DD/YY) _________________ Total Paid ($ Amount) ____________________________
Quantity of Drug ________________________ Days' Supply ___________________________________

Prescription (Rx) Number ______________
Drug Name ________________________ National Drug Code (NDC Number) ______________________
Date Filled (MM/DD/YY) _________________ Total Paid ($ Amount) ____________________________
Quantity of Drug ________________________ Days' Supply ____________________________________

Prescription (Rx) Number ______________
Drug Name ________________________ National Drug Code (NDC Number) ______________________
Date Filled (MM/DD/YY) _________________ Total Paid ($ Amount) ____________________________
Quantity of Drug ________________________ Days' Supply ____________________________________

For Compound Prescriptions Only (if covered)				
Drug's 11 Digit NDC Number	Ingredient Name	Quantity	Days Supply	Drug Cost
		Total Paid by Cardholder		
Administration Fee __________________ Total Paid by Cardholder ______________				

Important: Your claim will be processed within 14 days of receipt. If we decide that the drug is covered and you followed all the rules for receiving the drug, we will mail your reimbursement of our share of the cost to you.

Send completed forms with pharmacy receipts to:

Mail

Leon Health, Pharmacy
Department 8600 NW
41st St, Doral, FL
33166

Email:
pharmacy@leonhealth.com

Fax: (305) 718-2864

Requestor Signature ____________________ Date ________________________

By completing this form, I understand that I am responsible for my part of the cost-share in accordance with my plan benefits.