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.