

Member Request for Reimbursement

Directions:

Please use this form when you have paid full price for a covered prescription drug and want to be reimbursed. If possible, include a copy of all prescription receipt(s) and prescription label(s) with your form. Receipts may contain the following information:

1. Prescription number
2. Date filled
3. Pharmacy NPI#
4. Drug name with NDC number
5. Drug strength, quantity, days' supply and amount paid

If you have any questions or concerns, please call **855-898-1480** (TTY users should call **711**), **Monday-Sunday 8 a.m to 8 p.m.** / Fax 844-328-1906. You can also call if you need help filling out this form.

Mail completed and signed forms to:

MeridianComplete
Attn: Pharmacy Reimbursement Requests
1 Campus Martius, Suite 750
Detroit, MI 48226

MeridianComplete is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-855-580-1689** (TTY: **711**).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-580-1689** (TTY: **711**).

Patient Information	
Patient Name:	Street Address:
Member ID#:	City:

Sex: Male Female		State & Zip:	
Date of Birth:		Phone:	
Contact Person:		Relationship to Patient:	
Reason for Request			
☐ No Identification Card Available		☐ Copayment issue	
☐ Out-of-network Pharmacy Used		☐ Pharmacy unable to process claim electronically	
☐ Emergency		☐ Other	
Explain reason for request: 			
Medication Information			
Medication #1:			
Name of Medication: _____	NDC: _____	Date of Fill: _____	Prescription Number: _____
Dr. Name: _____	NPI: _____	Amount Paid: _____	Quantity/Days Supply: _____
Medication #2:			
Name of Medication: _____	NDC: _____	Date of Fill: _____	Prescription Number: _____
Dr. Name: _____	NPI: _____	Amount Paid: _____	Quantity/Days Supply: _____
I certify that the prescription(s) referred to above have been received and the information is accurate. I certify that the patient for whom this reimbursement is submitted is a covered person and that the prescription(s) given are for the sole use of the member identified. I release all information pertaining to the above claim(s) to the plan administrator, underwriter, sponsored policy holder and/or any person or entity acting on the behalf of the member at their request. Member Signature*: _____ Date: _____ *If the member is unable to sign, a person who is authorized to do so under the state of law in the state where the individual resides must sign above. This signature certifies that the person is authorized under state law to complete the form on the member's behalf and that all documentation of the authority will be available on request by the plan by the Center for Medicare & Medicaid Services or the state Medicaid agency.			

MeridianComplete (Medicare-Medicaid Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MeridianComplete does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MeridianComplete:

- 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 MeridianComplete Member Services.

If you believe that MeridianComplete has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with MeridianComplete's Grievance Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, MeridianComplete's Grievance Coordinator is available to help you.

Mail: MeridianComplete
Attn: Medicare Grievance Coordinator
P.O. Box 44260
Detroit, MI 48244

Telephone: 1-855-580-1689
(TTY users should call 711)
Hours: Monday – Sunday, 8 a.m. to 8 p.m.
Fax: 1-313-294-5552
Email: medicaregrievances@mhplan.com

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, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

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

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-580-1689 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-580-1689 (TTY: 711).

繁體中文 (Chinese): 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1-855-580-1689 (TTY : 711) 。

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-580-1689 (TTY: 711) 번으로 전화해 주십시오.

Tagalog (Tagalog-Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-580-1689 (TTY: 711).

العربية (Arabic): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-580-1689 (رقم هاتف الصم والبكم: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-580-1689 (телетайп: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-580-1689 (TTY: 711).

اُردو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ - کال کریں 1-855-580-1689 (TTY: 711).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-580-1689 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-580-1689 (TTY: 711).

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-580-1689 (TTY: 711) पर कॉल करें।

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-580-1689 (ATS : 711).

λληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-580-1689 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-580-1689 (TTY: 711).