meridian

Member Request for Reimbursement

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 **1-855-580-1689** (TTY: **711**), Monday-Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also call if you need help filling out this form.

Mail completed and signed forms to:

Meridian Medicare-Medicaid Plan
Attn: Pharmacy Reimbursement Requests
1 Campus Martius, Suite 750
Detroit, MI 48226

Patient Information			
Patient Name:		Date of Birth:	
Member ID#:		Gender:	❑ Male ❑ Female
Street Address:		City:	
State:	Zip Code:	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.

Meridian Medicare-Medicaid Plan (MMP) is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees.

ATENCIÓN: **Si habla español,** tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-580-1689** (los usuarios de TTY deben llamar al **711**). Los representantes están disponibles para ayudarle de lunes a viernes de 8 a.m. a 8 p.m. Los fines de semana y los días feriados estatales o federales, es posible que se le solicite que deje un mensaje. Su llamada será devuelta dentro del siguiente día hábil. La llamada es gratis.

You can get this document for free in other formats, such as large print, braille, or audio. Call **1-855-580-1689** (TTY: **711**). Representatives are available Monday-Friday, 8 a.m. to 8 p.m. to assist you. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.