Prescription Drug Claim Form

You are not required to use this form to request a reimbursement. This form encompasses standard reimbursement requests, as well as requests for Compound Claims. If your drug is not a compound, some of the requested fields may not be applicable. Please fill out as much information as you have available. Any blank fields we will attempt to obtain directly from your pharmacy.

Please indicate the reason for your reimbursement request.

- ☐ I did not have my member ID card at the time of purchase.
- ☐ I was charged for medication(s) received during an urgent care/emergency visit.
- ☐ I was administered a Medicare Part D covered vaccine in my doctor's office.
- ☐ Primary coverage is with another insurance carrier. (Coordination of Benefits)
- ☐ Other: _____

Part 1: Member Information

1. Complete ALL information. Your ID Number can be located on the front of your member ID card.
2. Submit claims within the filing period specified in your Evidence of Coverage. For questions about the filing period, please review your Evidence of Coverage or call Health Pointe Direct Complete Plan (HMO I-SNP) Member Services at either 1-844-269-3442 or 1-718-637-2075 (local) (TTY: 711). Hours of operations: From October 1 to March 31, we are open 7 days a week, from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we are open Monday through Friday, from 8 a.m. to 8 p.m. EST.
3. Requests for reimbursement may be made by the member; the member's prescribing physician or provider, or the member's representative. If someone other than the member is requesting this reimbursement please include a completed Appointment of Representative form with your request.
4. Please submit a separate form for each patient for which you purchased medications.

First Name	Last Name	MI
Telephone Number ( )	Date of Birth	Gender (Circle One) Male Female
ID Number	Subscriber's Employer (PCN)	
Mailing Address		
City	State	ZIP Code
Member Signature		Date Signed

Part 2: Pharmacy Information

1. Complete ALL information.
2. Please submit a separate form for each pharmacy from which you purchased medications.

Name		
Street Address		
City	State	ZIP Code
Pharmacy or Provider of Service National Provider Number (NA if not available)		Telephone Number ( )

For Reimbursement of Compound Drug Preparation, see the table below.
Please indicate the time spent preparing the compound drug in the Receipt Information on page 2.

Time	Reimbursement
1 – 4 minutes	$15.00
5 – 14 minutes	$25.00
15 – 29 minutes	$35.00
30 -59 minutes	$50.00
60+ minutes	$75.00

Part 3: Receipt Information

1. Include Proof of Payment with the original pharmacy receipt(s) or pharmacy printout(s). Cash Register Receipt(s) without pharmacy detail will not be accepted. Tape all receipt(s) to the bottom of this page. Please DO NOT staple.
    a. Compound medications must have at least 2 ingredients, and at least 1 ingredient must be a Federal legend drug.
    b. All active ingredients must be covered as part of your formulary and all script information must be submitted.
2. Please provide the explanation of benefits (EOB) or denial letter from the primary insurance carrier if you have primary coverage with another insurance carrier.
3. Receipts will not be returned, remember to keep a copy of the completed claim form and receipt(s) for your records.

Part 4: Drug Information: *This information should be listed in your original pharmacy receipt, pharmacy printout, or Medical Invoice. If the receipt or invoice is missing any of this information, please ask your pharmacist or Medical Provider to help fill in the missing details. If you are unable to obtain the information we will attempt to contact your pharmacy, however it may result in a delay of processing your claim.*

Date Rx Filled	Diagnosis Code and Description	Medication Name
Rx Number	Final Form of Compound (cream, patches, suppository, suspension, etc.)	
National Drug Code	Quantity	
Day Supply	Total Volume (grams, ml, each, etc.)	
Prescribing Physician First/Last Name		Prescribing Physician NPI
Original Cost of Rx	Amount Primary Insurance Paid on Rx	Member Paid Amount

Compound Ingredients

	Ingredient Name	Ingredient NDC	Metric Decimal Quantity	AWP/WAC
1				
2				
3				
4				

Reimburse (Circle One)	
Pharmacy	Member

Total Ingredient Cost	
Preparation Time	
Member Copay	

Mail this form along with receipts to:
Health Pointe Direct Complete Plan (HMO I-SNP) Manual Claims
PO BOX 1039
Appleton, WI 54912-1039

Or Fax this form along with receipt to:
1-855-668-8550

Health Pointe Direct Complete Plan (HMO I-SNP) is required by federal law to provide the following information.

Health Pointe Direct Complete Plan (HMO I-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Pointe Direct Complete Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Pointe Direct Complete Plan provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Health Pointe Direct Complete Plan provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Customer Care Center at 1-844 269-3442.

If you believe that Health Pointe Direct Complete Plan (HMO I-SNP) 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. If you need help filing a grievance, The Grievance Department is available to help you. You can file a grievance in person or by mail, fax, or email:

Grievance Department
810 7th Ave, Suite 801
New York, NY 10019
Phone: 1-844-269-3442
Email: Grievance@healthpointeny.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, 800-537-7697 (TDD)

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

Health Pointe of New York

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-269-3442 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-269-3442 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电1-844-269-3442 (TTY 711). 我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-844-269-3442 (TTY 711). 我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-269-3442 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-269-3442 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương trình sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-269-3442 (TTY 711). Sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-269-3442 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-844-269-3442 (TTY 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-269-3442 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. سيقوم شخص ما يتحدث24439624481للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على. مبساعدتك. هذه خدمة مجاني ةلاعربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना केबारे में आपकेकिसी भी प्रश्न केजवाब देने केलिए हमारे पास मुफ्त दुभाषिया सेवाएँउपलब्ध हैं. एक दुभाषिया प्राप्त करने केलिए, बस हमें 1-844-269-3442 (TTY 711). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-269-3442 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-269-3442 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-269-3442 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-269-3442 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-269-3442 (TTY 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。