FUTURE SCRIPTS *Secure*®

Medicare Part D Prescription Claim Form

Part 1 – Beneficiary Information

ID Number:	Name:

Street Address:

City, State, Zip Code:

Telephone (include area code):

Date of Birth:	Gender: (circle one) M or F

Part 2 – Coordination of Benefits

Is this medication covered under any other insurance plan? (circle one)   Yes or No
 If yes, go to next question

What is the name of the other insurance company?

Is the other insurance plan primary or secondary? (circle one) **primary or secondary**
If it is secondary, include the secondary insurance explanation of benefits with this form.

Did you use your Medicare Part D Card to pay for this prescription(s)? (circle one)   Yes or No
If no, go to next question.

If you did not use your Medicare Part D card, why? *Check (✓) reason below or explain.*

☐ *ID card was rejected at pharmacy*

☐ *Did not have my card with me*

☐ *Price was less at pharmacy, or I used a pharmacy/store discount card*

☐ *Prevent my out of pocket drug costs from counting towards my Medicare Part D drug spend*

☐ *Other (please explain):*

Important: Signature required to acknowledge understanding of the statement below.

The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I may be disenrolled from the plan.

Signature:	Date:

Stop here if you are including original pharmacy receipt(s). *(not register receipts)*

Part 3: Take to the pharmacy to complete ONLY if original pharmacy receipt(s) are not enclosed.

To ensure that the plan participant receives accurate and timely reimbursement for medicine purchases, please assist in completing the information below. If this is a compound prescription, enter COMPOUND RX in the space designated for the NDC # and complete the Compound Prescriptions section on the reverse side.

Pharmacy Name	Pharmacy NPI #

Pharmacy Address

I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the plan beneficiary.

Signature of Pharmacist or Representative:	*Date:*

Rx #	Date Filled	Prescriber NPI #	Drug Name and Strength	
NDC #		Metric Quantity	Day Supply	Total Charge

Part 4: Take to pharmacy to complete ONLY for compounded prescriptions *(include pharmacy receipts).* **Complete a new form for each compounded prescription.**

Compounded Prescription Name (Label-Name)	Total Cost of All Ingredients $	Dispensing Fee $	Sum of all Charges $
Ingredient	**NDC#**	**QTY Used (include UOM)**	**Ingredient Cost**

How to complete this form

1. **Complete all plan participant information in Part 1 on reverse side.**
   - The ID number can be found on your ID card
   - Sign and date the prescription claim form in the spaces provided. Your signature certifies that the information is correct and complete.
2. **Either have the pharmacy complete Part 3 on the front page or provide the original pharmacy receipt(s) that includes the following information:**
   - Pharmacy Name, Address, Telephone Number and Provider Number (NCPDP/NABP or NPI)
   - Prescriber's Name or Prescriber Number (NPI)
   - Medication Name, Strength, NDC #, Quantity and Days Supply
   - Prescription Number, Total Cost Paid by Beneficiary, Date of Service
3. **A separate form should be completed for:**
   - Each beneficiary/family member
   - Each pharmacy
   - Each prescription for which reimbursement is requested
4. **If you have questions, need help completing the form or require additional claim forms, contact FutureScripts® Secure at 1-888-678-7015.**
   - Customer Service is available to assist you seven days a week from 8 a.m. to 8 p.m. EST.
5. **To avoid delays in handling your claim, please be sure all information is complete and correct.**

*Please keep copies of all receipts mailed to FutureScripts® Secure; documents will not be returned.

Where to send the form

Mail completed form with original receipt(s) to:
>   **Catamaran**
>   **P.O. Box 968021**
>   **Schaumburg, IL 60196-8021**

For Official Use Only

☐ Compound

☐ PA

IPNS CODE

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