

CLAIM FORM INSTRUCTIONS

Part 1: Member Information

- Complete all information under Part 1. Your CarePlus ID Number is on your member ID card.
Note: Prescriptions that are filled by pharmacies outside the United States and its territories are not covered; e.g., cruise ships.

Part 2: Receipt Information

- Include all original pharmacy receipts and patient package insert(s) if applicable. Cash register receipts are not sufficient. Tape receipt(s) and patient package insert(s) to a separate page and submit with claim form. If medication was provided in ER or doctor’s office, provide itemized statement.
- Receipt(s) must contain the information outlined under Part 2 of the claim form below.

Part 3: Pharmacy Information

- Provide information about the pharmacy or doctor’s office where medications were obtained.
- Please submit a separate form for each pharmacy from which you purchase medications.

If your receipt(s) and insert(s) are missing any of the required information, please ask your pharmacy or doctor’s office to provide it. Remember to keep a copy of the completed claim form and receipt(s) for your records.

If you have any questions, please call Member Services at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail message after hours, Saturdays, Sundays, and holidays, and we will return your call within one business day.

Once all sections have been filled in, please sign and date. Your signature attests that all information is accurately represented by the completed form and accompanying documents.

Mail the completed form, receipt(s), and patient package insert(s) to:

CarePlus Health Plans, Inc.
Attention: Member Services Department
11430 NW 20th Street, Suite 300
Miami, FL 33172

PART 1: MEMBER INFORMATION

CarePlus ID Number	Date of Birth (mm/dd/yyyy)		
_____	_____		
Member Last Name	First Name	MI	
_____	_____	_____	
Gender	Person Completing This Form		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		
Member Street Address	_____		
_____	_____		
City	State	ZIP Code	Member Telephone
_____	_____	_____	_____

Patient Residence:	
<input type="checkbox"/>	Home
<input type="checkbox"/>	Nursing Home
<input type="checkbox"/>	Assisted Living
<input type="checkbox"/>	Group Home
<input type="checkbox"/>	Intermediate Care
<input type="checkbox"/>	Hospice

PART 2: RECEIPT AND/OR PATIENT PACKAGE INSERT INFORMATION

Ensure your receipt includes the following information:

- | | |
|--|---|
| <input type="checkbox"/> Date Filled | <input type="checkbox"/> Quantity |
| <input type="checkbox"/> Medication Name | <input type="checkbox"/> Days Supply |
| <input type="checkbox"/> Medication Strength | <input type="checkbox"/> Rx Price (including tax) |
| <input type="checkbox"/> Dosage Form | <input type="checkbox"/> Physician Name |
| <input type="checkbox"/> Rx Number | <input type="checkbox"/> Physician ID (NPI or DEA#) |
| <input type="checkbox"/> National Drug Code (NDC)* | |

**In case of compound(s), NDCs for every ingredient are listed.*

Dispense as Written (DAW): This code is a message from your doctor to the pharmacist about using generics. If it applies to your prescription, it can be found on your pharmacy label or your pharmacy can provide it.

- DAW: 0 – Not Applicable 1 – Doctor mandates that brand product be dispensed
 2 – Patient mandates that brand product be dispensed 5 – Brand submitted as generic
 7 – Brand mandated by state law

PART 3: PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy ID (NABP or NPI#) _____

Pharmacy Street Address _____

City _____ State _____ ZIP Code _____ Pharmacy Telephone _____

- Pharmacy Service Type: Retail Compounding Home Infusion Institutional Mail Order
 Long Term Care Managed Care Organization Specialty Other

Description

- of Issue: Pharmacy will not accept my CarePlus plan I was administered a Part D covered vaccine in my doctor's office
 Pharmacy was unable to process my claim electronically I filled my medication during an emergency
 I did not have my plan information at the time of purchase I have drug coverage with a plan in addition to CarePlus (Coordination of Benefits):
 I was charged for medications received during an Emergency Room visit Name of Insurance Co.: _____
 I believe the claim was paid incorrectly Insurance Co. Phone: _____
Employer Name: _____
Member ID: _____

Please explain the issue:

IMPORTANT CLAIM NOTICE

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person:
(1) files an application for insurance or statement of claim containing any materially false information; or
(2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act.

Member Signature _____ Date _____

NOTE: If this form is signed by anyone other than the member, additional documentation is required authorizing that representative. This may include an Appointment of Representative (AOR) form or statement, a Power of Attorney (POA), or other legal documentation. An AOR form is available at www.CarePlusHealthPlans.com/members/forms-tools-resources for your convenience.

IMPORTANT!

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. CarePlus complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CarePlus, there are ways to get help.

- You may file a complaint, also known as a grievance, with:
CarePlus Health Plans, Inc. Attention: Member Services Department.
11430 NW 20th Street, Suite 300. Miami, FL 33172.
If you need help filing a grievance, call **1-800-794-5907 (TTY: 711)**. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.
- 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, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

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

Auxiliary aids and services, free of charge, are available to you.

1-800-794-5907 (TTY: 711)

CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.

1-800-794-5907 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвони е по номеру, указанному выше, ч обы получи ь беспла ные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resewva sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

ગુજરાતી (Gujarati): નિઃશુલ્ક ભાષા સહાય સેવાઓ પ્રાપ્ત કરવા માટે ઉપરોક્ત નંબર પર કોલ કરો.

ภาษาไทย (Thai): โทรติดต่อที่หมายเลขด้านบนนี้เพื่อรับบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย.

Diné Bizaad (Navajo): Wóda'hí béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé níká'adoowoł.

العربية (Arabic):

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك