Coordination of Benefits / Direct Claim Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

IBM medco®

Member/Subscriber Information *See your prescription drug ID card.*

Group No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last)

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year) ☐☐ ☐☐ ☐☐☐☐

Sex
☐ Female
☐ Male

Relationship to Plan Member
☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible Child
☐ 7 Domestic Partner
☐ 8 Other

Pharmacy Information

Name of Pharmacy

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐Yes ☐No

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Medco or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X _____ _____

Signature of Pharmacist or Representative **(Required)** **NABP Number Required**

Claim Receipts

Tape receipts or itemized bills on the back. **See back for details.**

Check the appropriate box if any receipts or bills are for a:

☐ **Compound prescription**
Make sure your pharmacist lists ALL the VALID 11 digit NDC numbers and ingredients and quantities on the receipt or bill.

☐ **Medication purchased outside of the United States**
Please indicate:
Country _____
Currency used _____

☐ **Allergy medication**

Coordination of Benefits

(Another Health Plan has paid a portion) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?
☐Yes ☐No

☐ 1 Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid
☐ 3 Card Program
☐ 3 HMO
☐ 5 Medco By Mail/mail-order pharmacy

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

Please tape receipts on the back.

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X _____

Signature of Member

(Only the Employee, Retiree, or Eligible Surviving Spouse is authorized to sign this form.)

IBM

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.

Tape receipt for prescription 1 here

Tape receipt for prescription 2 here

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (Drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

I certify that the information below and submitted with this claim form is accurate.

I authorize release of any information relating to this claim to IBM, its contract administrators, or their representatives, as necessary to determine the validity or amount payable on account of this claim. I agree that IBM's contract administrators may release to IBM, or any contract administrator designated by IBM, upon IBM's request, any records and information in its possession in connection with this claim. Information may also be used for other reporting and analysis purposes without identification of the undersigned and the undersigned's family. A photostatic copy of this authorization shall be as effective as the original.

I understand that if I file or authorize another to file a claim knowing that:

1. a provider has waived part or all of a fee or other charge listed in the claim; or
2. the claim contains false, deceptive or misleading information or a deceptive or misleading omission, then I may be subject to dismissal, loss of eligibility under the plans and/or criminal prosecution.

Reimbursement for Overpayment: I hereby agree to notify IBM promptly if I become aware of any overpayment of this claim; and to reimburse IBM for any amount by which a claim payment is finally determined to have exceeded the applicable benefit.

When To Use This Form

- Use this form to submit claims for prescription drug benefits including: Coordination of Benefits, Out of Network Claims and Foreign Claims.
- You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
- You must submit claims no later than December 31 of the year following the year in which the charges are incurred or no benefit will be payable.

Another Health Plan Paid

You must first submit the claim to the primary insurance carrier. Once the Statement from the Primary Plan is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided above, and attach the Statement from the Primary Plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription Drug Programs or HMO Plans

Retail Pharmacies: If the primary plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipt(s) that shows the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

Medco By Mail/mail-order pharmacy: If the primary plan is **Medco By Mail,** complete this form and attach either the prescription receipt(s) that shows the co-payment or coinsurance amount paid to the mail-order pharmacy, or the statement of benefits you receive from the mail-order pharmacy.

* California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

* Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Instructions

Read carefully before completing this form

1. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
2. The plan member should read the acknowledgment carefully, then sign and date this form.
3. Return the completed form and receipt(s) to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

- Claims will only be paid for dependents who are enrolled in an eligible IBM Plan at the time the expense is incurred. Enrollment questions should be directed to the IBM Employee Services Center at 1-800-796-9876 (TTY: 1-800-426-6537). Questions regarding the processing of claims should be directed to Member Services at 1-800-987-5254 (TTY: 1-800-289-1089). From overseas: 1-800-497-4641.
- Keep a copy of this claim form and supporting bills for your records. This will help you reconcile them to the Explanation of Benefits you will receive. Copies will not be provided.
- Be sure this form is completed in full, signed, and dated. Incomplete or improperly completed claim submissions will be returned for correction and resubmission.

Visit us online anytime at **www.medco.com.**

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