



**Medicare Part D Vaccine and Administration (Injection) Claim Form**

This claim form is for reimbursement of covered Part D vaccines and their administration (injection). Please consult your Evidence of Coverage for specific coverage information.

**Instructions for completing this form are located on the back of this form.**

**Please review the instructions prior to completing this form.**

**Part 1- Please complete Part 1 fully to ensure proper reimbursement of your claim.**

Please type or print clearly.

|   |   |       |                |
|---|---|-------|----------------|
| <b>Plan Participant Information</b><br>(Please use a separate claim form for each cardholder) | ID Number:  | Name: | Date of Birth: |
|   | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |       |                |
|   | Address   |       | Apt .          |
|   | City  | State | Zip Code       |
|   | Telephone (include area code)   |       |                |

**Fraud Prevention Regulation:** I certify that I have received the medicine described herein and that I am the plan participant named and am eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to FutureScripts® Secure, the prescription benefit manager; the insurance underwriter; sponsor; and/or policyholder. I certify that all the information entered on this form is correct. By signing this form, I certify that I have no intent to defraud the insurer and this claim does not contain or conceal any false or misleading information. I understand that false or misleading statements may be subject to criminal and/or civil penalty.

X

Signature required to acknowledge understanding of the statement above.      Date

**Part 2 - Remember to include original pharmacy receipts. Keep copies for your records.**

|   |                               |       |          |  |
|---|-------------------------------|-------|----------|--|
| <b>Dispensing Pharmacy Information</b><br>(If purchased at a pharmacy, have pharmacy complete.) | Pharmacy Name                 |       |          | <p align="center"><b>This claim is for:</b><br/>(Please check ✓ all that apply.)</p> <input type="checkbox"/> The vaccine<br><input type="checkbox"/> The administration (injection) of vaccine.<br><input type="checkbox"/> Both the vaccine and the administration |
|   | National Provider ID Number   |       |          |  |
|   | NCPDP Provider ID Number      |       |          |  |
|   | Telephone (include area code) |       |          |  |
|   | Address                       |       |          |  |
|   | City                          | State | Zip Code |  |

**Part 3 - Remember to include original doctor's office receipts. Keep copies for your records.**

|  |                               |       |          |  |
|--|-------------------------------|-------|----------|--|
| <b>Physician Information</b><br>(If obtained from or administered at doctor's office, have office complete.) | Physician Name                |       |          | <p align="center"><b>This claim is for:</b><br/>(Please check ✓ all that apply.)</p> <input type="checkbox"/> The vaccine<br><input type="checkbox"/> The administration (injection) of vaccine.<br><input type="checkbox"/> Both the vaccine and the administration |
|  | National Provider ID Number   |       |          |  |
|  | Telephone (include area code) |       |          |  |
|  | Address                       |       |          |  |
|  | City                          | State | Zip Code |  |

**Part 4 - Remember to include original receipts. Original receipts must contain required information. This form may be used for Part D Vaccines, some examples are listed below. Keep copies for your records.**

**Vaccine Prescription Information** (Complete if vaccine was obtained or administered in a pharmacy or physician's office)

- Required Information:**
- ✓ Please obtain information from your physician or pharmacy if it is not provided as part of your receipt or bill.
  - ✓ You must enclose the receipt(s) for the vaccine and/or administration with this form.
  - ✓ Complete one line for each vaccine. Be sure the charges for the vaccine(s) and the administration(s) are separated in the table below so we can reimburse you properly.

|                          | RX # - if received at pharmacy | Drug Name | 11 Digit NDC # |  |  |  |  |  |  |  |  |  |  | Quantity | Date Filled | Date Administered | Vaccine Charge | Admin. Fee |  |  |
|--------------------------|--------------------------------|-----------|----------------|--|--|--|--|--|--|--|--|--|--|----------|-------------|-------------------|----------------|------------|--|--|
| <input type="checkbox"/> | Example                        | Zostavax  |                |  |  |  |  |  |  |  |  |  |  |          |             |                   |                |            |  |  |
| <input type="checkbox"/> |                                |           |                |  |  |  |  |  |  |  |  |  |  |          |             |                   |                |            |  |  |
| <input type="checkbox"/> |                                |           |                |  |  |  |  |  |  |  |  |  |  |          |             |                   |                |            |  |  |
| <input type="checkbox"/> |                                |           |                |  |  |  |  |  |  |  |  |  |  |          |             |                   |                |            |  |  |
| <input type="checkbox"/> |                                |           |                |  |  |  |  |  |  |  |  |  |  |          |             |                   |                |            |  |  |
| <input type="checkbox"/> |                                |           |                |  |  |  |  |  |  |  |  |  |  |          |             |                   |                |            |  |  |
| <input type="checkbox"/> |                                |           |                |  |  |  |  |  |  |  |  |  |  |          |             |                   |                |            |  |  |
| <input type="checkbox"/> |                                |           |                |  |  |  |  |  |  |  |  |  |  |          |             |                   |                |            |  |  |

**How to complete this form and where to mail :**

- Complete all plan participant information in Part 1 on reverse side.**
- The Plan Participant 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.
  - Please make a copy of all documents and receipts before you send them to FutureScripts® Secure. No documents will be returned.
  - If you have questions, please contact: FutureScripts® Secure toll-free at 1-888-678-7015, seven days a week from 8 a.m. – 8 p.m. EST.

Mail To: **FutureScripts® Secure**  
**Medicare Part D Paper Claims**  
**P.O. Box 37694**  
**Philadelphia, PA 19101-0694**

**For Official Use Only**

Compound       PA

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