Medicare Generation Rx
EMPLOYER PDP

Mail completed form to:
Attn: Claims Department
Medicare GenerationRx
P.O. Box 509099
San Diego, CA 92150-9099

Medicare Prescription Drug Coordination of Benefits/Claim Form

Be sure to complete all information below and submit this form along with the original prescription label. Do not staple your prescription label to this form; tape it to a separate sheet of paper for submission with this completed form. Missing information will delay your reimbursement. Submitting a claim form does not guarantee reimbursement. If you have any questions, please call Member Services at 1-877-MedRxHelp (1-877-633-7943), 24 hours a day, 365 days a year. (TDD/TTY users, please call 711)

Member ID Number	
Group Number	
Member Last Name	
Member First Name	
Date of Birth	Month / Day / Year
Member Address ***(address where reimbursement should be sent)***	Street 1 Street 2 City State / Zip
Member Signature	Sign Here
Telephone Number	Area Code – **Date**

Reason for Reimbursement Request (check one) - ***You may submit a claim for your Part D covered drugs provided by a non-network pharmacy only for the reasons listed below.***

- ☐ Coordination of Benefits – Another health plan has paid a portion. (Include your pharmacy receipt(s) identifying copays paid ***and*** an Explanation of Benefits from the primary insurance plan.)
- ☐ I traveled outside the plan's service area and ran out of or lost my medication, or I became ill and could not access a network pharmacy.
- ☐ I used a prescription discount card.
- ☐ My health plan/insurance information or Member ID Card was not available at the time.
- ☐ There was no network pharmacy in my area or within a reasonable driving distance.
- ☐ The pharmacy was unable to process my claim.
- ☐ I received a Part D covered vaccine in my doctor's office or clinic (cost for vaccine and administration fees must be listed separately)
- ☐ I was evacuated or displaced from my home due to a state or federally declared disaster or health emergency.
- ☐ Emergency – describe emergency:

Pharmacy/Provider Information - ***Attach original prescription label. Cash register receipts alone are not acceptable. If no receipt is available, complete this section and have the pharmacist sign to verify your receipt of the prescription.***

RX Number	**Date Filled** Month / Day / Year	**New** ☐ **Refill** ☐	**Quantity**	**Day Supply**
National Drug Code (11 digit)			**Medication Name & Strength**	**Prescriber Name**
RX/Vaccine Price $	**Co-Pay** $		**Administration Cost** $	
Pharmacy Name	**Pharmacy Telephone Number**		**NPI Number**	
Pharmacy Street Address	**City, State**		**Zip Code**	
Pharmacist's Signature:				

For Compound Prescription Only:

(Pharmacist must complete and attach the original pharmacy label.)

RX Number												**Date Filled** Month / Day / Year	
Valid 11 Digit NDC Number *(for each ingredient)*											**Drug / Ingredient** *(tablets, grams, etc.)*	**Quantity**	**Charge**
												Total $	
Pharmacist's Signature:												**Date:**	

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.

AL, AK, AZ, CT, DE, GA, ID, IL, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OR, RI, SC, SD, VT, WI, WY Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties. **Additionally, DE, ID, MN, NM, OH Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or criminal penalties. **AR, CA, DC, FL, HI, MD, ME, OK, TN, TX, UT, VA, WA, WV Residents: WARNING –** For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information is guilty of a crime and may be subject to imprisonment, fines, and/or denial of insurance benefits. **Additionally, AR, CA, FL, MD, OK, TX, UT, WV Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or confinement in prison. **CO Residents: WARNING –** For your protection, state law requires the following statement to appear on this form. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department or regulatory agencies. **NY Residents: WARNING –** For your protection, state law requires the following statement to appear on this form. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **PA Residents: WARNING –** For your protection, state law requires the following statement to appear on this form. Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.