

Medicare and Medicare-Medicaid Plans Prescription Claim Form

You can use this form to ask us to pay for our share of your covered drugs. Check your Evidence of Coverage or Member Handbook for more information.

If you wish to have a person complete this form on your behalf, please check this box and return a completed *Appointment of Representative* form (page 2) along with the prescription claim form.

INSTRUCTIONS:			
1. Complete this form. 2. Staple pharmacy receipt(s) to the form (we can't accept cash register receipts) and mail to:			
Medicare Part D Pharmacy Claims PO Box 419069 Rancho Cordova, CA 95741-9069			
MEMBER INFORMATION:			
Member ID #:		Group #:	
Last name :	First name :	MI:	Phone #:
Address:	City:	State:	ZIP code:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth: ___/___/_____		
Has your claim been processed with another insurance carrier? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, attach a copy of your Explanation of Benefits (EOB) or a statement from your other insurance to your pharmacy receipt(s).			
Name of other insurance company:		Other insurance policy number:	
Name of other insurance policyholder:		Name of policyholder's employer:	
Other insurance type: <input type="checkbox"/> Single <input type="checkbox"/> Family			
Other comments: _____ _____ _____			
I certify that the above information is correct.			
X _____ <div style="text-align: center;">Member's Signature</div>		_____/_____/_____ <div style="text-align: center;">Date</div>	

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)
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Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date
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Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date
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Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee **must** be waived for representation

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit <https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html>, or call 1-800-MEDICARE (1-800-633-4227) for more information.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



Section 1557 Non-Discrimination Language
Notice of Non-Discrimination

Allwell complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Allwell does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Allwell:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Allwell’s Member Services telephone number listed for your state on the Member Services Telephone Numbers by State Chart. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Allwell has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number in the chart below and telling them you need help filing a grievance; Allwell’s Member Services is available to help you.

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 (TTY: 1-800-537-7697).

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

Member Services Telephone Numbers by State Chart

State	Telephone Number and Plan Type
Arizona	1-800-977-7522/1-877-935-8020 (HMO and HMO SNP) (TTY: 711)
Arkansas	1-855-565-9518 (HMO) (TTY: 711)
Florida	1-844-293-2636 (HMO); 1-877-935-8022 (HMO SNP) (TTY: 711)
Georgia	1-844-890-2326 (HMO); 1-877-725-7748 (HMO SNP) (TTY: 711)
Illinois	1-855-766-1736 (HMO) (TTY: 711)
Indiana	1-855-766-1541 (HMO and PPO); 1-833-202-4704 (HMO SNP) (TTY: 711)
Kansas	1-855-565-9519 (HMO); 1-833-402-6707 (HMO SNP) (TTY: 711)
Louisiana	1-855-766-1572 (HMO) (TTY: 711)
Mississippi	1-844-786-7711 (HMO); 1-833-260-4124 (HMO SNP) (TTY: 711)
Missouri	1-855-766-1452 (HMO); 1-833-298-3361 (HMO SNP) (TTY: 711)
New Mexico	1-844-810-7965 (HMO SNP) (TTY: 711)
Ohio	1-855-766-1851 (HMO); 1-866-389-7690 (HMO SNP) (TTY: 711)
Pennsylvania	1-855-766-1456 (HMO); 1-866-330-9368 (HMO SNP) (TTY: 711)
South Carolina	1-855-766-1497 (HMO and HMO SNP) (TTY: 711)
Texas	1-844-796-6811 (HMO); 1-877-935-8023 (HMO SNP) (TTY: 711)
Wisconsin	1-877-935-8024 (HMO SNP) (TTY: 711)

Section 1557 Non-Discrimination Language
Multi-Language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the Member Services number listed for your state in the Member Services Telephone Number Chart.

SPANISH: ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al número del Departamento de Servicios al Afiliado que se enumera para su estado en la Ficha de Números de Teléfono del Departamento de Servicios al Afiliado.

VIETNAMESE: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin vui lòng gọi số điện thoại phục vụ hội viên dành cho tiểu bang của quý vị trong Bảng số điện thoại dịch vụ hội viên.

CHINESE: 請注意: 如果您使用中文，您可以免費獲得語言援助服務。請撥會員服務部電話號碼表所列的您所在州的會員服務部號碼。

FRENCH CREOLE (HAITIAN CREOLE): ATANSYON: Si w pale kreyòl ayisyen, ou ka resevwa sèvis gratis ki la pou ede w nan lang pa w. Rele nimewo sèvis manm pou eta kote w rete a. W ap jwenn li nan tablo nimewo telefòn sèvis manm yo.

ARABIC:

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. اتصل برقم خدمات الأعضاء المدرج في لائحة رقم هاتف خدمات الأعضاء الخاص بالولاية المقيم فيها.

FRENCH: ATTENTION : Si vous parlez français, un service d'aide linguistique vous est proposé gratuitement. Veuillez appeler le numéro de téléphone du Service aux membres spécifique à votre État qui se trouve dans le tableau de numéros de téléphone du Service aux membres.

RUSSIAN: ВНИМАНИЕ! Если Вы говорите на русском языке, мы можем предложить Вам бесплатные услуги переводчика. Позвоните в Отдел обслуживания участников по указанному для Вашего штата номеру в телефонном справочнике Отдела обслуживания участников

GERMAN: ACHTUNG: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie bitte die für Ihren Bundesstaat zuständige Rufnummer des Mitgliederkundendienstes an, die im Telefonverzeichnis des Mitgliederkundendienstes angegeben ist.

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, may makukuha ka na mga libreng serbisyon pantulong sa wika. Tawagan ang numero ng Mga Serbisyo ng Miyembro na nakalista para sa iyong estado sa Tsart ng Numero ng mga Serbisyo ng Miyembro.

PORTUGUESE: ATENÇÃO: Se falar português, estão disponíveis, gratuitamente, serviços de assistência linguística. Ligue para o número dos Serviços aos Membros indicado para o seu estado na Tabela de números de telefone destes serviços.

PENNSYLVANIAN DUTCH: Geb Acht: Wann du Deitsch schwetze kannscht, un Hilf in dei eegni Schprooch brauchst, kannscht du es Koschdefrei griege. Ruf die Glieder Nummer von dei Staat, ass iss uff die Lischt an die Glieder Hilf Telefon Nummer Kaart.

GUJARATI: સાવધાન: જો તમે ગુજરાતી બોલતા હો તો, ભાષા સહાય સેવાઓ, ન:શિલ્ક, તમારા માટે ઉપલબ્ધ છે. સભ્ય સેવા ટેલફોન નંબર ચાર્ટમાં તમારા રાજ્ય માટે સૂચવિદ્ધ સભ્ય સેવાઓ નંબર પર કોલ કરો.

JAPANESE: 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。メンバーサービス電話番号チャートに記載されているお住まいの州のメンバーサービスまでお電話ください。

ITALIAN: ATTENZIONE: se parla italiano, sono disponibili per Lei servizi di assistenza linguistica gratuiti. Consulti la Tabella dei Numeri Telefonici dei Servizi per i Membri e chiami il numero dei Servizi per i Membri del Suo stato.

MARSHALLESE: LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin eo am̄ ilo ejjelōk wōñāān ñan kwe. Kaļļok nōm̄ba in telpon in Jermal in Jipañ ñan ro Uwaan eo ej jeje ñan state eo am̄ ilo Jaat in Nōm̄ba in Telpon in Jermal in Jipañ ñan ro Uwaan.

LAOTIAN: ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄວ້ອ້ອຍຖ້າບໍ່ມີການທ່ານ ໂດຍບໍ່ສະຄຳ. ກະລຸນາໂທຫາເລກໝາຍບໍລິການສະມາຊິກທະບູລີໃນລັດຂອງທ່ານໃນແຜນພູມລະຫວ່າງໂທລະສັບ ບໍລິການສະມາຊິກ.

HMONG: CEEV FAJ: Yog koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau tus xov tooj ntawm Lub Chaw Pab Cuam Tswv Cuab ntawm koj lub xeev ntawm Tus Xov Tooj Ntawm Lub Chaw Pab Cuam Tswv Cuab Hauv Daim Ntawv No.

KOREAN: 알림사항: 귀하가 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 받으실 수 있습니다. 가입자 서비스 전화번호 표에 있는 귀하의 주 가입자 서비스 안내번호로 전화하십시오.

HINDI: ध्यान दें: यदि आप हिन्दी भाषी हैं, तो आपके लिए, भाषा सहायता सेवाएं, मुफ्त में, उपलब्ध हैं। सदस्य सेवा टेलीफोन नंबर चार्ट में अपने राज्य के लिए सूचीबद्ध सदस्य सेवा नंबर पर कॉल करें।

POLISH: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług tłumaczeniowych. Zadzwoń pod numer działu obsługi klienta odpowiedni dla twojego stanu, dostępny w Wypisie numerów telefonu działu obsługi klienta.

THAI: โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถขอรับบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย โทรไปยัง หมายเลขบริการสมาชิกที่ระบุไว้ในรัฐของคุณในแผนภูมิหมายเลขโทรศัพท์สำหรับบริการสมาชิก

AMHARIC: ማሳሰቢያ: አማርኛ የሚያወጥ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች ያለክፍያ አለልዎት። በ አባላት አገልግሎት የስልክ ቻርጅ ላይ ባለው በአባላት አገልግሎት ቁጥር ይደውሉ።

PERSIAN:

توجه: اگر به زبان فارسی صحبت می کنید، خدمات امداد زبانی به طور رایگان در اختیار شما می باشند. با شماره تلفن خدمات اعضا برای ایالت خود که در جدول شماره تلفن های خدمات اعضا ذکر شده تماس بگیرید.

BURMESE: သတိပုဂ္ဂိုလ်: ဗမာစကားပြောလျှင်၊ သင့်အတွက် ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများ အခမဲ့ ရရှိနိုင်ပါသည်။ အဖွဲ့ဝင်ဝန်ဆောင်မှုများ တယ်လီဖုန်းနံပါတ်ဇယားထဲ၌ သင့်ပုဂ္ဂိုလ်အတွက် စာရင်းသွင်းထားသည့် အဖွဲ့ဝင်ဝန်ဆောင်မှုများနံပါတ်ကို ဖုန်းခေါ်ပါ။

DUTCH: GRAAG UW AANDACHT: Indien u Nederlands spreekt, zijn taaldiensten gratis voor u beschikbaar. Gelieve de Ledendienstenummer vermeld voor uw staat in de Ledendiensten Telefoonnummer Tabel op te bellen.

PUNJABI: ਧਿਆਨ ਦੇਵੋ: ਜੇਕਰ ਤੁਸੀ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਬਨਿ ਕਸਿ ਮੁੱਲ ਦੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਦੇ ਟੈਲੀਫੋਨ ਨੰਬਰ ਚਾਰਟ ਵਿੱਚ ਤੁਹਾਡੀ ਸਟੇਟ ਦੇ ਲਈ ਦੱਸੇ ਗਏ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਦੇ ਨੰਬਰ ਉੱਤੇ ਫੋਨ ਕਰੋ।

SWAHILI: TAHADHARI: Kama unazungumza Kiswahili, huduma ya msaada wa lugha, bure, zinapatikana kwa ajili yako. Piga Nambari ya Huduma ya Mwanachama iliyoorodheshwa ya jimbo lako kwenye hiyo Chati ya Nambari za Simu za Huduma ya Mwanachama.

