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Instructions for the Part D prescription drug reimbursement form

Quartz Medicare Advantage (HMO)
2650 Novation Parkway • Fitchburg, WI 53713
(800) 394-5566 or TTY: 711
QuartzBenefits.com/MedicareAdvantage

Quartz Medicare Advantage (HMO) and Dual Eligible members: **Please read the following instructions before completing this form.**

What do you need to know about this form

The Quartz Medicare Advantage Part D prescription drug reimbursement form is a tool to help get your claim paid as soon as possible. We do not require you to use this form. You may submit similar written documentation, but it must provide ALL of the requested information on this form. Please note that missing, incomplete, or hard-to-read documentation can delay the successful processing of your claim.

When to use this form

You can use this form to request reimbursement for any of the following Medicare Part D prescription drug benefits:

- **Routine prescriptions:** You purchased a medication without using your member ID card.
- **Hospital observation:** You were admitted to the hospital for up to three days for observation, and you were not allowed to bring your daily drugs from home. During the observation, the only medications covered by Medicare Part D are those that are administered because you take them regularly (daily) at home.
- **Medicare Part D vaccines:** You purchased or had administered a Part D-approved vaccine.

How to submit a receipt

- Quartz Medicare Advantage **requires a receipt to properly reimburse you** for a Medicare Part D prescription drug claim. Review the **Acceptable receipts** section to learn more about what are considered acceptable receipts for reimbursement. Please note that a cash register receipt is not sufficient. We recommend that you tape your receipt(s) to an 8.5” x 11” sheet of paper or submit a clear photocopy.

Acceptable receipts:

- **Prescription receipt:** This receipt shows the pharmacy information, date of service, physician, Rx number, drug name, eleven-digit NDC, quantity, day’s supply, and the amount you paid. This is usually the receipt attached to the outside of the prescription envelope. Alternatively, you may ask for a prescription history report from your pharmacy for a given time period. As long as it shows all of the information noted in this paragraph and is signed by the pharmacist, this can serve as your pharmacy prescription receipt.

(Continue to the next page)

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- **Physician invoice:** This will generally come from your doctor if you have been administered a vaccine. It should provide the doctor's information (e.g., name, address, and phone number), date of service, drug name, drug NDC, and the amount you paid, including any administration fee.
- **Hospital invoice:** This will be an itemized statement from the hospital resulting from an observation stay. It must include the hospital pharmacy NPI number, date of service, physician name, drug name, drug NDC, quantity, day's supply, and paid amount. Please circle the drugs on the statement that you are requesting reimbursement. Only circled drugs will be considered for reimbursement.

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Part D prescription drug reimbursement form

Quartz Medicare Advantage (HMO) and Dual Eligible members: Use this form to request reimbursement for covered Medicare Part D medications purchased at retail cost. Complete one form per member. **Additional information and instructions are available on the first page. Please read carefully before completing this form.**

Member information		
Member ID (see ID card):	Date of birth (mm/dd/yyyy):	
Last name:	First name:	MI:
Mailing street address:		Apt. #
City:	State:	Zipcode:

Prescriber/pharmacy information where medication was received	
Prescriber/facility name:	Dispensing pharmacy name:
Prescriber/facility phone:	Dispensing pharmacy phone:

Reason for request

Please check (☑) the reason for your request. (Additional reasons for request on the next page.)

☐ **I used an out-of-network pharmacy for one of the following reasons:**

- ☐ I received a vaccine and/or vaccine administration in a physician's office (clinic or hospital setting) or an out-of-network pharmacy.
- ☐ I received medication from a health care facility, such as an emergency room, provider-based clinic, outpatient surgery, or other observation-type stay.
- ☐ I traveled outside my plan's service area and used the Quartz Medicare Advantage travel benefit.
- ☐ I could not get medication promptly at a network pharmacy within a reasonable driving distance, or 24 hours, seven days a week service was not available.
- ☐ I could not get medication anywhere other than a specific specialty pharmacy or directly shipped from the manufacturer.
- ☐ I was evacuated or displaced from my home due to a state or federally-declared disaster or health emergency.
- ☐ I filled a compound medication outside of the Quartz Medicare Advantage network.

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- ☐ **I did not use my Quartz Medicare Advantage member ID card.**
- ☐ **I was retroactively enrolled in the plan.**
- ☐ **I was waiting for a coverage decision on my medication.**
- ☐ **My pharmacy billed the wrong plan/insurance.**
- ☐ **My primary coverage is with another insurance plan (coordination of benefits).**
- ☐ **Other (please explain):**

Any additional information you would like Quartz to consider:

Payment information

Quartz Medicare Advantage requires a receipt to properly reimburse you for a Medicare Part D prescription drug claim. Please see **How to submit a receipt** and **Acceptable receipts** in the instructions for guidance on submitting a receipt.

- ☐ **Receipt included with the form.**

Member signature

Reimbursement of submitted claims is subject to your Part D prescription benefit and is not guaranteed. The reimbursement will be made according to the limits of your prescription benefit plan and will only be for the amount your plan would have paid on your behalf. The reimbursement amount may be significantly lower than the original amount you paid.

Quartz Medicare Advantage may return or deny hard-to-read or incomplete claims. If someone submits the claim on the patient's behalf, an Appointment of Representative form (Form CMS-1696) must be included with this form. The form is available on the Forms and Resources page at **QuartzBenefits.com/MedicareAdvantage**.

Signature: ______________________________ Date:______________

How to submit a claim

Return the completed form and receipt using one of the below options:

By mail:
Attn.: Pharmacy Part D
Quartz Health Solutions, Inc.
2650 Novation Parkway
Fitchburg, WI 53713

By Fax: (608) 881-8398
Please use one claim form per fax. Do not combine claims for different members in the same fax submission. Part D prescription drug reimbursement requests may be submitted up to 36 months from the date of service.

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NOTICE OF NONDISCRIMINATION

Quartz Medicare Advantage (HMO) and Quartz Med Advantage Dual Eligible w/Rx are the marketing names operating under the entities of Quartz Health Plan Corporation and Quartz Health Plan MN Corporation. These companies are separate legal entities. In this notice, "we" refers to these companies. We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, gender identity, or sexual orientation.

- We provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- We provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact **Customer Success** at **(800) 362-3310.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, or sexual orientation, you can file a grievance with:

Kristie Breunig, Compliance Officer; 2650 Novation Parkway, Madison, WI 53713
Phone: (800) 362-3310; TTY: 711 or toll free (800) 877-8973; Fax: (608) 644-3500
Email: AppealsSpecialists@QuartzBenefits.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kristie Breunig, Compliance Officer, 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 **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, D.C. 20201
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html.**

Multi-Language Insert

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-394-5566 (TTY: 711).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-394-5566 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-394-5566（TTY：711）。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-394-5566 (TTY: 711).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية متاحة من أجلك، يُرجى الاتصال على الرقم 1-800-394-5566 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-394-5566 (телетайп: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-394-5566 (711)번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-394-5566 (TTY: 711).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-394-5566 (TTY: 711).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-394-5566 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-394-5566 (ATS : 711).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-394-5566 (መስማት ለተሳናቸው: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-394-5566 (TTY: 711) पर कॉल करें।

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-394-5566 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-394-5566 (TTY: 711).