



**Gateway Health Plan Medicare Assured® HMO
Pharmacy Direct Reimbursement Claim**

INSTRUCTIONS FOR COMPLETING THE CLAIM FORM ARE ON THE REVERSE SIDE

PART ONE: To Be Filled Out By You

0 3 7 4			/ /
MEMBER ID		CARDHOLDER NAME	DATE OF BIRTH
ADDRESS - STREET			()
CITY			TELEPHONE
	STATE	ZIP	SEX <input type="checkbox"/> M <input type="checkbox"/> F

I certify that the medication(s) described below was received for use by the member listed, and that I (and the member, if not myself) am/are eligible for drug benefits. 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. Any person who knowingly files a claim containing any misinterpretation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature of Member, Guardian or Legal Representative: X

PART TWO: Pharmacy Information - To Be Filled Out By You or Your Pharmacist

PHARMACY NAME	ADDRESS - STREET
CITY	()
STATE	ZIP
	PHARMACY TELEPHONE

Rx 1	Rx 2
Date of Service: _____	Date of Service: _____
NDC: _____	NDC: _____
Prescription Number: _____	Prescription Number: _____
Quantity: _____ Days Supply: _____	Quantity: _____ Days Supply: _____
Amount Paid: _____	Amount Paid: _____
Rx 3	Rx 4
Date of Service: _____	Date of Service: _____
NDC: _____	NDC: _____
Prescription Number: _____	Prescription Number: _____
Quantity: _____ Days Supply: _____	Quantity: _____ Days Supply: _____
Amount Paid: _____	Amount Paid: _____



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INSTRUCTIONS

Please wait until you receive your Gateway Health Plan Medicare Assured® HMO I.D. card before sending this claim for reimbursement of prescription drug expenses. Please be sure to provide the proper ID # from your Gateway Health Plan Medicare Assured® HMO Identification Card to expedite claim processing.

- To avoid undue delay, please complete all sections on the claim form.
If you need assistance completing this claim form, please call the Gateway Health Plan Medicare Assured® HMO Pharmacy at 1-800-685-5209, 8:00 a.m. to 8:00 p.m., 7 days a week. TTY/TTD users should call 1-800-654-5988.
Attach itemized pharmacy receipt that contains the same information that is on the label of your prescription.

Note: Claim submission is not a guarantee of payment.

Note: Claims must be submitted within 60 days following the end of the calendar year in which the prescription drug was filled.

HOW TO COMPLETE THIS FORM

PART ONE

Member Information

- 1. Copy the 10 digit Member Identification Number (ID#) from your Gateway Health Plan Medicare Assured® HMO Identification Card.
2. Cardholder name (Member Name), Address and Telephone Number
3. Member Date of Birth: Month, Day, Year.
4. Member Sex: Check Male or Female

MAIL THIS FORM TO:

Gateway Health Plan®
U.S. Steel Tower, Floor 41
Pharmacy Department
600 Grant St.
Pittsburgh, PA 15219

PART TWO

Pharmacy Information (SEPARATE FORMS MUST BE FILLED OUT FOR EACH PHARMACY)

- 1. Pharmacy name, address and telephone number where the prescription(s) were purchased.
2. Fill in boxes Rx1, Rx2, Rx3 & Rx4 to include the Date of Service (date prescription filled), NDC Number, Rx Number, Quantity, Days Supply and Amount Paid. This information is printed on the Pharmacy receipt and the label on your prescription container.

NOTE: Do NOT submit cash register receipt(s).

Gateway Card Sample

Sample Gateway Health Plan Medicare Assured card showing member information (ID#, Name, DOB, PCP) and pharmacy information (Name, Address, Phone, Website) with contact numbers for member services and claims.