meridiancomplete
A WellCare Company
1 Campus Martius, Suite 700
Detroit, MI 48226

1-855-323-4578
TTY: 711
www.mhplan.com

Member Request for Reimbursement

Directions:
Please use this form when you have paid full price for a covered prescription drug and want to be reimbursed. If possible, include a copy of all prescription receipt(s) **and** prescription label(s) with your form. Receipts may contain the following information:

1. Prescription number
2. Date filled
3. Pharmacy NPI#
4. Drug name with NDC number
5. Drug strength, quantity, days' supply and amount paid

If you have any questions or concerns, please call **855-580-1689** (TTY users should call **711**), **Monday- Sunday 8 a.m.-8 p.m.** / Fax 844-882-9799. You can also call if you need help filling out this form.

Mail completed and signed forms to:

MeridianComplete
Attn: Pharmacy Reimbursement Requests
1 Campus Martius, Suite 750
Detroit, MI 48226

MeridianComplete is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

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Patient Information	
Patient Name:	Street Address:
Member ID#:	City:
Sex: Male Female	State & Zip:
Date of Birth:	Phone:
Contact Person:	Relationship to Patient:

Reason for Request	
☐ No Identification Card Available	☐Copayment issue
☐ Out-of-network Pharmacy Used	☐Pharmacy unable to process claim electronically
☐ Emergency	☐Other

Explain reason for request:
_____
_____

Medication Information			
Medication #1:			
Name of Medication: _____	NDC: _____	Date of Fill: _____	Prescription Number: _____
Dr. Name: _____	NPI: _____	Amount Paid: _____	Quantity/Days Supply: _____
Medication #2:			
Name of Medication: _____	NDC: _____	Date of Fill: _____	Prescription Number: _____
Dr. Name: _____	NPI: _____	Amount Paid: _____	Quantity/Days Supply: _____

I certify that the prescription(s) referred to above have been received and the information is accurate. I certify that the patient for whom this reimbursement is submitted is a covered person and that the prescription(s) given are for the sole use of the member identified. I release all information pertaining to the above claim(s) to the plan administrator, underwriter, sponsored policy holder and/or any person or entity acting on the behalf of the member at their request.

Member Signature*: _____ Date: _____

*If the member is unable to sign, a person who is authorized to do so under the state of law in the state where the individual resides must sign above. This signature certifies that the person is authorized under state law to complete the form on the member's behalf and that all documentation of the authority will be available on request by the plan by the Center for Medicare & Medicaid Services or the state Medicaid agency.

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MeridianComplete (Medicare-Medicaid Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MeridianComplete does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MeridianComplete:

- Provides 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)
- Provides 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 MeridianComplete Member Services. If you believe that MeridianComplete 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 with MeridianComplete's Grievance Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, MeridianComplete's Grievance Coordinator is available to help you.

Mail:	MeridianComplete Attn: Medicare Grievance Coordinator P.O. Box 44260 Detroit, MI 48244	Telephone: Hours: Fax: Email:	1-855-323-4578 (TTY users should call 711) Monday – Sunday, 8 a.m. to 8 p.m. 1-313-294-5552 medicaregrievances@mhplan.com

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, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

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

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-323-4578 (TTY: 711).

العربية (Arabic): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-323-4578 (رقم هاتف الصم والبكم: 711).

繁體中文 (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1-855-323-4578 (TTY: 711)。

Tagalog (Tagalog-Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-323-4578 (TTY: 711).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-855-323-4578 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-323-4578 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-323-4578 (TTY: 711)로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-323-4578 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-323-4578 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-323-4578 (TTY: 711).

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-323-4578 (TTY: 711).

বাংলা (Bengali): লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-1-855-323-4578 (TTY: ১-711)।

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-323-4578 (TTY: 711) まで、お電話にてご連絡ください。

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-323-4578 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ܐܬܘܪܝܐ (Assyrian): ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܡܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܡܨܝ ܐܢܬ ܕܡܦܠܚܬ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-855-323-4578 (TTY: 711)