Michigan Department of Community Health (MDCH) Member Mail Order Co-pay Reimbursement Requests Instructions

You must use a *Michigan Claim Form* to ask for repayment for out-of-pocket mail order drug co-pays if the mail order pharmacy that your primary insurance uses does not participate with MDCH. Participating pharmacies will submit a claim for you.

The sample form at the end of these instructions can be used to ask for up to two mail order drug co-pays. To ask for extra forms, contact the Magellan Medicaid Administration Member Call Center toll free at 1-877-681-7540. If all the fields on the form are not filled out, the form will be returned to you. You will need to fill out the missing fields and then resubmit the form.

Please print using blue or black ink. Grayed boxes are for official use only.

Step 1: Instructions for Completing the Form

(1) I.D. – Print the member's 10-digit ID (for example: the 10-digit Medicaid ID)

(2) Patient Name – Print the member's name

(4) Patient Date of Birth – Print the member's date of birth (MM/DD/CCYY) (for example: 04/01/2000)

(5) Patient Gender Code – Print '1' for male or '2' for female

(7) Address – Print the address of the patient

(8) City – Print the city of the patient

(9) State & Zip Code – Print the city and zip code of the patient

(10) Pharmacy Name – Print the name of the mail order pharmacy

(11) Patient Address – Print the address of the mail order pharmacy

(12) City – Print the city of the mail order pharmacy

(13) State & Zip Code – Print the city and zip code of the mail order pharmacy

(14) Service Provider ID – Print the mail order pharmacy's National Provider Identifier (NPI) (10 digits). If this is not found on your prescription bottle, then you may need to call your mail order pharmacy to ask them for this number.

(15) Phone No – Print the phone number of the mail order pharmacy (if available)

(16) Fax No – Print the fax number of the mail order pharmacy (if available)

(18) Certification

- ❒ *Circle* 1 or 2 based on the number of mail order drugs you reported on this form

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- ❒ Read the certification statement before you sign the form

(19) PRESCRIPTION / SERV REF# - Print the mail order pharmacy's Rx number for your medicine

(21) Date Written – Print the date the mail order pharmacy filled your medicine (MM/DD/CCYY) (for example: 04/01/2010)

(22) Date of Service –Print the date the mail order pharmacy filled your medicine (MM/DD/CCYY) (for example: 04/01/2010)

(23) FILL # - Print '0' if this is a new prescription and print '1' if this is a refill

(24) QTY Dispensed – Print the metric quantity of your medicine filled by the mail order pharmacy (for example: 100)

(25) Days Supply – Print the days supply of the medicine filled by the mail order pharmacy

(26) Unit of Measure – Print the unit of measure of the medicine filled by the mail order pharmacy (for example: ea, ml, or gm)

(27) Product/Service I.D. – Print the National Drug Code (NDC) of the medicine filled by the mail order pharmacy (this is found on your prescription bottle)

(29) Prescriber I.D. – Print your doctor's NPI number (10 digits). If this is not found on your prescription bottle, then you may need to call your mail order pharmacy to ask them for this number.

(31) PROVIDER I.D. – Print the mail order pharmacy's National Provider Identifier (NPI) (10 digits). Same as number 11.

(33) USUAL & CUST. CHARGE – Print the co-pay amount you paid to get your medicine filled by the mail order pharmacy

Step 2: Attach your Receipt for the Mail Order Drug

This receipt must show the co-pay amount you paid, identify the mail order pharmacy, and contain the details from your medicine.

Step 3: Mail the Form

Paper Claims Processing Unit
P O Box 85042
Richmond, VA 23261-5042