MassHealth Member Pharmacy Mail Order Expense Reimbursement Form

MassHealth may be able to reimburse members for their out-of-pocket mail order pharmacy expenses for MassHealth covered services when a MassHealth member is seeking to fill a mail order pharmacy prescription(s) and is required to pay the mail order pharmacy expense (including co-insurance, co-payments, and deductibles) up front to the provider in compliance with their private insurance coverage policy. This enhanced benefit allows members to fill their mail order prescriptions quickly at no extra cost to them.

To ensure your request is received and processed in a timely manner, please include all information requested on this form and return along with an Explanation of Benefits (available through your insurance company) for the dates of service where you were charged an out-of-pocket expense. If there is incomplete documentation, this could delay the verification of your out-of-pocket expenses, which could cause a delay in issuing payments. The Benefit Coordination and Recovery Program (BCR) will review your mail order out-of-pocket pharmacy expense reimbursement request and will contact you (or parent\guardian) if there are questions. Once reviewed, approved and processed, the MassHealth reimbursement will be disbursed within 21 calendar days. Questions about the status of the reimbursement request can be directed to the BCR Customer Service line at (800) 462-1120.

Note: It is recommended that the reimbursement request be submitted within one year of the date of service for any out-of-pocket expenses to ensure timely processing of your request. You may submit up to 5 dates of service per reimbursement request.

Reimbursement Checklist:

- ☐ The prescription was filled by a required out-of-state mail order provider, not a retail pharmacy.
- ☐ The service qualifies for Pharmacy Out-of-Pocket Mail Order reimbursement.
- ☐ The member is an eligible MassHealth member on the date(s) of service.
- ☐ The documentation submitted agrees with the requested refund amount.
- ☐ The refund request contains sufficient proof of payment, i.e., cancelled check, credit card statement.
- ☐ An Explanation of Benefit (EOB) from the Mail Order Pharmacy is attached to support the refund request.
- ☐ Shipping and handling expenses are not to be included in the requested reimbursement amount.

Definitions:

1.	**Name**	Your name as it appears on your MassHealth ID card
2.	**MassHealth Member ID Number**	12-digit member ID number on your MassHealth ID card
3.	**Date of Birth**	MM/DD/YYYY
4.	**Address**	Complete address to send the reimbursement check
5.	**Phone Number**	Preferred daytime contact number we can use to reach you if we have questions
6.	**Date of Service**	Date that you received the service from the mail order pharmacy
7.	**Type of Service Received**	What service did you receive from the mail order pharmacy (needs to be a MassHealth **covered** pharmacy service)
8.	**Mail Order Pharmacy Name**	Name of the Mail Order Pharmacy
9.	**Mail Oder Pharmacy Address**	Address for Mail Order Pharmacy
10.	**Mail Order Pharmacy Phone Number**	Phone number for Mail Order Pharmacy
11.	**Member Out-of-Pocket Expense**	The amount of copay/deductible/coinsurance listed on the EOB as member responsibility or the amount you paid for the service received

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12.	**EOB**	Explanation of Benefits — Obtained through your insurance company or Mail Order Pharmacy. Including this with the reimbursement form will help speed up processing time.
13.	**Proof of Payment**	Documentation that the member paid the mail order expense out-of-pocket to the Mail Order Pharmacy such as the cancelled check, credit card statement, etc.

Instructions:

1. Complete **this form in its entirety and** sign below.
2. Provide the **Explanation of Benefits (EOB) for the services received.**
3. Provide **Supporting Payment Information such as cancelled check or credit card statement.**
4. Return completed form in one of the following ways:
   a. **Mail:** Benefit Coordination and Recovery Program, 529 Main St, Suite 302, Charlestown, MA 02129
   b. **Fax:** (617) 886-8134 (Subject Line: Benefit Coordination and Recovery Refund Request)

Part 1: Member & Policyholder Information

1. Member Name: _____
2. MassHealth Member ID Number: _____ 3. Date of Birth: _____
4. Member Address (Street, City, State, ZIP): _____
5. Member Phone Number: _____
6. Insurance Policy Number: _____
7. Policy Holder Name: _____
8. Relationship of Policy Holder to Member (Self, Parent, etc.): _____

Part 2: Information about Service Received

1. Date(s) of Service (DOS), Member Expense ($), and Prescription Name – Limit five per reimbursement request:

	DOS 1	DOS 2	DOS 3	DOS 4	DOS 5
Date of Service					
Expense ($)					
Prescription Name					

2. Mail Order Pharmacy Name: _____
3. Mail Order Pharmacy Address: _____

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Part 3: Payment Information

Payment should be sent to:

☐ Member listed in Part 1 ☐ Member Parent/Guardian

1. Member Address (Street, City, State, ZIP): _____

2. Attention to Member or Parent/Guardian Name: _____

3. Receiver of Reimbursement (provide one of the following):

   • MassHealth ID #: _____

   Or if not a MassHealth member:

   • SSN #: _____

Signature:

I certify under pains and penalty of perjury that what is stated on this form is correct and complete to the best of my knowledge.

Member or Parent/Guardian Signature: _____ Date: _____