

## MANUAL CLAIM FORM VTPART D CLAIM - NCPDP vD.0

**Return to: Optum** 

45 Commerce Dr Suite 5

Augusta, ME 04330 Fax Number: 1-844-679-5366

| Patient Name                    |                      |                     |         | Cardholder ID           |                          |               |  |                     |   |     | Pharmacy Name |                  |                            |             |         |              |      | N                     | NABP               |                       |   |     |              |                  |                  |  |  |
|---------------------------------|----------------------|---------------------|---------|-------------------------|--------------------------|---------------|--|---------------------|---|-----|---------------|------------------|----------------------------|-------------|---------|--------------|------|-----------------------|--------------------|-----------------------|---|-----|--------------|------------------|------------------|--|--|
|                                 |                      |                     |         |                         |                          |               |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| Street Address                  | City                 |                     | Plan Na | me                      | Patient DOB              |               |  |                     | Gene                                    | der | Pha           | Pharmacy Address |                            |             |         |              | N    | NPI                   |                    |                       |   |     |              |                  |                  |  |  |
| Direct Hadress                  |                      |                     |         | 1 1011 1 (0             |                          |               |  |                     |   |     |               | 1 1100           |                            |             |         |              |      |                       | -                  | 12.2                  | T | T   | Τ            |                  |                  |  |  |
|                                 |                      |                     |         |                         |                          |               |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| Claim 1                         |                      |                     |         |                         |                          |               |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| Comments:                       |                      |                     |         | Other Coverage Code   F |                          |               |  | Benefit Stage 01(DE |   |     |               | (DEI             | ED) Benefit Stage 02 (INI  |             |         |              |      | T)                    |                    | Benefit Stage 03(GAP) |   |     |              |                  |                  |  |  |
|                                 |                      |                     |         |                         |                          |               |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| Rx Number                       | Ref#                 | Ref # Prescriber NP |         |                         |                          | Prescriber Na |  |                     | Vame                                    |     |               |                  | Date Pres                  |             |         | scribed Date |      |                       | led                | Quantity              |   |     | Days' Supply |                  |                  |  |  |
|                                 |                      |                     |         |                         |                          |               |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| DA II                           | a.                   | u d D Mc            |         |                         |                          | MDC           |  |                     |   |     |               |                  | DDD C                      |             |         | <u> </u>     | U&C  |                       |                    | Conson A mil          |   |     |              |                  |                  |  |  |
| PA#                             | MN Drug Name,        |                     |         |                         | Strength, Dosage, Mfg.   |               |  |                     | NDC                                     |     |               |                  |                            |             |         | PDP Copay    |      |                       | Ingredient<br>Cost |                       |   | U&C |              |                  | Gross Amt<br>Due |  |  |
|                                 |                      |                     |         |                         |                          |               |  |                     | Т                                       | ПТ  |               |                  |                            |             |         |              |      | Cost                  |                    |                       |   |     | Duc          |                  |                  |  |  |
|                                 |                      |                     |         |                         |                          |               |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| <b>Coordination of Benefits</b> | (COR) = O            | ther Pav            | er Info | rmation                 | <u> </u>                 |               |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
|                                 | Payer D              |                     |         |                         |                          |               |  | cts OPAP            |   |     |               |                  |                            |             |         |              | OPPR | PRA                   |                    |                       |   |     |              |                  |                  |  |  |
| 1                               |                      | Qual. Other Payer I |         |                         |                          |               |  |                     |   |     | Qual          |                  | Α                          | Amt         |         | Qual Am      |      | t                     | Qual               |                       |   |     | A            | Amt              |                  |  |  |
|                                 |                      |                     |         |                         |                          |               |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| 2                               |                      |                     |         |                         |                          |               |  |                     |   |     | Qua           | al Amt           |                            | mt          | Qual An |              | Amt  | nt Qual               |                    |                       |   | A   | Amt          |                  |                  |  |  |
| Claim 2                         |                      |                     |         |                         |                          |               |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| Comments:                       |                      |                     |         | Other Coverage Code Be  |                          |               |  |                     | Benefit Stage 01(DED)                   |     |               |                  | D) Benefit Stage 02 (INIT) |             |         |              |      | Benefit Stage 03(GAP) |                    |                       |   |     |              |                  |                  |  |  |
|                                 |                      |                     |         |                         |                          |               |  |                     | ·                                       |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| Rx Number                       | oer NPI              | I # Prescriber N    |         |                         |                          |               | Vame                                   |                     |   |     | Date Prescr   |                  |                            | cribed Date |         |              | led  |                       | Quantity           |                       |   | Dav | s' Su        | pply             |                  |  |  |
| Rx Number Ref # Prescriber NF   |                      |                     |         | 110001100111            |                          |               |  |                     | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |     |               |                  |                            |             |         |              | 2 40 |                       |                    | - Comments            |   | ,   | 24)          | <i>,</i> 24      | PP-J             |  |  |
|                                 |                      |                     |         |                         |                          |               | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ |                     |   |     | 1 222 2       |                  |                            |             |         |              |      |                       | 770.0              |                       |   |     |              |                  |                  |  |  |
| PA # MN Drug Name, S            |                      |                     |         |                         | trength, Dosage, Mfg. NI |               |  |                     |   | NDC |               |                  |                            | PDP Cop     |         |              |      |                       |                    | t U&C                 |   |     |              | Gross Amt<br>Due |                  |  |  |
|                                 |                      |                     |         |                         |                          |               |  |                     |   |     | T             |                  |                            |             |         |              |      | Cost                  |                    |                       |   |     |              | Due              |                  |  |  |
|                                 |                      |                     |         |                         |                          |               |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| <b>Coordination of Benefits</b> |                      |                     |         |                         |                          |               | _                                      |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
|                                 | ID Qual. Other Payer |                     |         | Date Other Pa           |                          |               | yer Re                                 | S                   | OPAP                                    |     |               |                  |                            |             | 1 1     |              |      | PRA                   |                    |                       |   |     |              |                  |                  |  |  |
| 1                               |                      |                     |         |                         |                          |               |  |                     |   |     |               | al               | A                          | mt          | Qual Ar |              | Am   | Qua                   | al                 |                       | 1 |     | A            | mt               |                  |  |  |
| 2                               |                      |                     |         |                         |                          |               |  |                     |   |     | Qua           | al               | A                          | mt          | Qι      | ıal          | Am   | Qua                   | ıl                 |                       |   |     | A            | mt               |                  |  |  |
|                                 |                      | <u> </u>            |         |                         | L                        |               |  |                     |   |     |               |                  | <u> </u>                   |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |
| Provider Signature              |                      |                     |         |                         | Da                       | Date Signed   |  |                     |   |     |               |                  |                            |             |         |              |      |                       |                    |                       |   |     |              |                  |                  |  |  |

Updated: 09/27/2024