Vaya Health

Prescription Drug Claim Form

Direct Member Reimbursement

Vaya Health (Vaya) contracts with Navitus Health Solutions, LLC (Navitus) to manage your pharmacy benefits. This claim form must be used to request reimbursement of covered prescription drug expenses from Navitus. Please check which reason applies:

☐ I did not have my Medicaid ID card with me at the time of purchase.
☐ I was charged for medication received during an urgent or emergency visit.
☐ My primary coverage is with another insurance carrier.

Additional explanation:

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ALERT for members whose claims were processed by the pharmacy using insurance or a discount card. *Please note that a discount card is not insurance.* Your plan may consider the claim fully paid. Additional reimbursement might not be provided.

PART 1: MEMBER INFORMATION

1. Complete ALL information. Your ID number is located on your Vaya Medicaid ID card.
2. Submit claims within 180 days of purchase at the pharmacy. For more information, review your Member Handbook or call Vaya's Member and Recipient Service Line at 1-800-962-9003 (available 7 a.m.-6 p.m., Monday-Saturday).
3. Submit a separate form for each Vaya member for whom you purchased medications.

First name:	Last name:	MI:
Phone number:	Date of birth:	ID number:
Street address:		
City:	State:	ZIP code:
Member signature:		Date signed:

PART 2: PHARMACY INFORMATION

1. Complete ALL information.
2. Submit a separate form for each pharmacy where you purchased medications.

Pharmacy name:		
Street address:		
City:	State:	ZIP code:
Pharmacy National Provider Number (NPI):		Phone number:

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PART 3: RECEIPT INFORMATION

1. Include original pharmacy receipt(s) or pharmacy printout(s). ***Cash register receipt(s) without pharmacy details will not be accepted.***
2. Receipt(s) must contain the information outlined below. If your receipt(s) are missing any of this information, have your pharmacist fill in the missing information.
3. If you have primary coverage with another insurance carrier, please provide the explanation of benefits (EOB) or denial letter you received from the primary insurance carrier.
4. An incomplete form may be denied, delayed, or returned.
5. Receipts will not be returned. Remember to keep a copy of the completed claim form and receipt(s) for your records.

Rx written date:	**Date Rx filled:**	**Rx number:**
Medication name:		
National Drug Code:	**Quantity:**	**Day supply:**
Prescriber first/last name:		**Prescriber NPI:**
Original cost of Rx:	**Amount paid by primary insurance (if applicable):**	
Member paid amount:		

Mail this form and your receipt(s) to:
Navitus Health Solutions, LLC
P.O. Box 999
Appleton, WI 54912-0999

OR

Fax this form and your receipt(s) to either number below:
920-735-5315
Toll-free: 1-855-668-8550

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