# Compass MED D - Researching and Submitting Paper Claims

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**Description:** This document provides the process for submitting a paper claim for reimbursement and then researching paper claim inquiries. The paper claim processing system provides a traditional paper claims reimbursement method for instances where a beneficiary must use out-of-network retail pharmacies, when circumstances require, they pay full price at an in-network pharmacy, or when they pay out of pocket at a doctor’s office, or for outpatient stays in a hospital.

| Researching Paper Claim Inquiries |
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Perform the following steps:

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| **Step** | **Action** | | | | |
| **1** | Determine if the beneficiary has already submitted a paper claim.   * If yes, research the paper claim and proceed to **Step 2.** * If no, run test claims for the date of service to verify coverage and then proceed to the [Submitting Paper Claims](#_Submitting_Paper_Claims) section.   **Note:** If beneficiary is returning a call regarding a previously submitted paper claim, then access the [Paper Claim Viewer in Compass](#_Paper_Claim_Viewer) to review all paper claims that have been received and processed:   * + - If the beneficiary would like to be transferred to the paper claim representative, ask the beneficiary to provide the number   and warm transfer the call to the paper claim representative.   * + - If the beneficiary would like to provide the CCR the information, a Support Task can be submitted.   CCR will submit a Support Task: Refer to [Compass - Create a Support Task](file:///C:\Users\C337799\Downloads\TSRC-PROD-050031).   * **Task Type:** Participant Research Request (CRR)   **Note:** Explain the reason for the call (verifying a call made by paper claims) and note any specific beneficiary requests  or information provided by the beneficiary. | | | | |
| **2** | Locate the claim in question. Navigate to the **Claims Landing Page** and click the **Filter** icon to open the **Filter** options.  **Note:** The **Claim Type** will be **Paper Claim.**     * From the **Claim Type** drop-down menu, select **Paper.** | | | | |
| **If the claim is...** | | **Then...** | | |
| Found | | Proceed to Step 3. | | |
| NOT Found | | Ask the caller when the claim was submitted and refer to the [Turn Around Times (TAT) - Paper Claims](#_Turn_Around_Times) section of this document to determine if enough time has elapsed for the reimbursement to be mailed. | | |
| **If...** | | **Then...** |
| Enough time (30-45 days) has elapsed since the claim was submitted | | View the **Member Alerts** to determine if the letter has been received.   * **If yes,** advise the caller that it has been received and that the packet has been rejected because it was missing information. Research the cause of the packet rejection in [Compass - Identifying Paper Claims](file:///C:\Users\c071417\Downloads\TSRC-PROD-050034) and advise the caller to resubmit with the appropriate information. Refer to [MED D - Paper Claim - Reject Reason Codes](file:///C:\Users\C337799\Downloads\TSRC-PROD-010081). * **If no,** verify the correct paper claims address and ask the caller to resubmit.   Refer to [Paper Claim Viewer in Compass](#_Paper_Claim_Viewer) and/or the [Turn Around Times (TAT) - Paper Claim](#_Turn_Around_Times) section.  **Notes:**   * If beneficiary has resubmitted multiple times without resolution, follow standard escalation procedures. * Paper Claims are not noted by the Claims department. |
| Beneficiary has not allowed enough processing time (30-45 days) | | 1. Remind the caller that our processing time begins once we receive the claim. 2. Advise them of the approximate date of receipt and the various options available for checking the status of the claim (callback, web). |
| Beneficiary states they received a Dismissal Notice | | Proceed to [Dismissal of Paper Claim](#_Dismissal_of_Paper). |
| **3** | Click the **Rx Number** hyperlink.    **Result:** The Prescription Details screen displays. | | | | |
| **4** | Determine if the claim was “Paid” or “Rejected” by reviewing the **Status** field on the Prescription Details screen.  **Note:** The number in **Claim / Sequence** field will match the number on the Prescription Claim Reimbursement Statement (PCRS) sent to the member. | | | | |
| **If the claim is …** | **Then...** | | | |
| Paid | 1. Click the **Financials Details** tab.     **Result:** The Financial Details screen displays.   1. Review the **Financial Details** screen in Compass (along with the Explanations of Benefit, refer to [Compass MED D - Explanations of Benefit](file:///C:\Users\c071417\Downloads\TSRC-PROD-061526)) for a detailed breakdown of how a paper claim paid and advise beneficiary accordingly.    1. The total amount will not always be reimbursed back to the beneficiary. The local pharmacy is allowed to charge what is called a “usual and customary” (U&C) amount for the drug dispensed. If a beneficiary fails to use their prescription benefits card, the pharmacy will not be able to determine the contracted amount between the PBM and the pharmacy. This means that the amount is not covered and is shown in the Total Excluded field.    2. Scroll to the bottom of the **Financial Details** screen in Compass, to view the **Member Reimbursement** section. CCRs can determine when a reimbursement check was issued and to whom it has been addressed.     **Member Reimbursment View**     1. Proceed to Step 5.   **The PBM is unable to change the amount to a covered amount.** If the beneficiary disagrees with the reimbursement amount, refer to [Beneficiary Disputes or Questions Reimbursement Amount on Rx](#_Beneficiary_Disputes_or). | | | |
| Rejected | Proceed to the next step. | | | |
| **5** | From the **Claim Details** tab, navigate to the **Messaging** subtab.   * Determine and advise the beneficiary of the reason for rejection and discuss any available options to resolve the issue. * Review the **Reject Code** (hyperlink) and **Reason Why Rejected** fields. Refer to [MED D - Paper Claim - Reject Reason Codes](file:///C:\Users\c071417\Downloads\TSRC-PROD-010081).       **Notes:**   * When a paper claim is denied, the beneficiary will not receive the original paperwork back. The paperwork is scanned into the system and the beneficiary will receive a copy of the scanned image. * If **Claims** require more research, refer to the [Scenario Guide](#_Scenario_Guide). | | | | |
| **6** | Address any other beneficiary questions: | | | | |
| **If...** | | | **Then...** | |
| A copy of the claim documents is being requested | | | Send an email to [ClaimPullRequests@CVSHealth.com](mailto:ClaimPullRequests@CVSHealth.com).  In the email, include the following:   * Member name * Member ID * Prescription numbers in question and the fill dates * Claim/Document # | |
| Beneficiary states they have submitted their paper claims multiple times and do not understand the reason(s) for denial | | | Transfer to the Senior Team. The senior team can verify the turnaround time.  Provide the senior resolution team beneficiary the following information:   * Member ID * Member Name * Date of Service * Client Code * Name of medication(s)   Refer to [MED D - When to Transfer Calls to the Senior Team](file:///C:\Users\C337799\Downloads\TSRC-PROD-018060) and [Basic Call Handling](file:///C:\Users\C337799\Downloads\TSRC-PROD-016401). | |

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| Submitting Paper Claims |
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Perform the steps below:

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| **Step** | **Action** |
| **1** | Read the disclaimer to the beneficiary:   The submission of a paper claim does not ensure reimbursement under the prescription benefit plan.  Advise the beneficiary to complete one of the below options in order to request a reimbursement:  **Submit:**   * A Paper Claim Form and proceed to **Step 2**. * Online through Desktop/Mobile Site or Mobile App. **Submission Requirements**, refer to the [Scenario Guide](#_Scenario_Guide). * Submitting **without** a Paper Claim form. **Submission Requirements,** refer to the [Scenario Guide](#_Scenario_Guide).   **Notes:**   * Claim forms are provided to all beneficiaries to complete and submit along with their prescription receipts for reimbursement per the plan design benefit. * Some Medicare D plans (with an AOB provision) allow the beneficiaries to assign their benefits to a pharmacy, provider, facility, or other individual (power of attorney, spouse, etc.) in lieu of receiving the reimbursement themselves. A [Compass MED D - Appointed Representative (AOR) Form or Power of Attorney (POA) 061884](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=64c3fc62-48c3-4ad3-ae83-c736cebd521b) document should be submitted with the Paper Claim. * If the beneficiary is deceased, a paper claim can still be submitted. If completing the Prescription Drug Claim Form, the beneficiary signature is not required. A [Compass MED D - Appointed Representative (AOR) Form or Power of Attorney (POA) 061884](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=64c3fc62-48c3-4ad3-ae83-c736cebd521b); however, will be required. * If the beneficiary asks the CCR to submit the paper claim form on their behalf, advise them in order to file the paper claim specific information will be needed that only they can provide.   **Example:** Detailed pharmacy prescription receipt.  **Additional Notes:**   * MED D Paper Claims have a **90 day electronic** **(at POS)** and a **3 year** **(manual claim form)** filing limit. * Payments should not be sent to the Paper Claims mailbox. * Some plans may have these benefits set up under a commercial secondary plan for their beneficiaries. * If the beneficiary used more than one pharmacy, each pharmacy will need to be submitted separately. |
| **2** | Submit a Paper Claim Form.  **Submit the following information:**   * A completed [Prescription Drug Claim Form](#_Prescription_Drug_Claim_1)   + If the beneficiary is assigning benefits to another party:     - The name and address of the assignee.     - Write “AOB” below the Member Information Section. * A **detailed pharmacy prescription receipt** along with any discount card that was used and the amount of the discount. * A detailed pharmacy prescription receipt includes the following information:   + - Rx Number     - NPI/NCPDP Number     - NDC Number     - Metric Qty/Days Supply Number     - DAW (if applicable)     - Dispensed Quantity     - DEA/NPI Number     - Date of Fill     - Cost of Medication   **Notes:**   * If the days’ supply is not listed on the receipt from the pharmacy, tell the plan beneficiary to contact his/her local pharmacy or pharmacist to ask for the information. Tell the plan beneficiary to either:   + Ask the local pharmacy to print a new receipt that includes the days’ supply;   + Ask the local pharmacy to print a report that includes the days’ supply information; or handwrite the days’ supply on the original receipt. * Claims that do not include the days’ supply will be returned to the plan beneficiary with a letter explaining how to obtain the days’ supply from the pharmacy. The days supply is necessary to ensure appropriate benefits consideration. Once the days’ supply has been obtained, the plan beneficiary should resubmit the claim form, a copy of the letter and the receipt(s) back to the PBM at the appropriate post office box. |
| **3** | Advise the beneficiary some claim types also have [Additional Paper Claim requirements](#_Other_Paper_Claim).  **Notes:**   * Foreign claims or prescriptions dispensed by a physician’s office **are not** reimbursable by Med D. * Some vaccines received in a physician’s office may be eligible for reimbursement.   + Proof of payment for vaccines administered in a prescriber/clinic setting, and the amount of any administration fee corresponding to the vaccine. |
| **4** | Provide the beneficiary with the address where they should submit their Paper Claim documents. Check the Client Information Form (CIF) for paper claims addresses. If no specific address is listed, use the general address:  **P.O. Box 52066**  **Phoenix, AZ 85072-2066**  **Note:** Ensure that all submitted documents are clear and legible. |
| **5** | Advise the beneficiary that their submitted claim will be adjudicated and processed according to the client’s specific plan design, and they will receive a Prescription Claim Reimbursement Statement (PCRS).   * **If the claim is approved for payment**, a reimbursement check for the prescription amount less the appropriate co-payment will be included with the statement.   See sample: [MED D - Prescription Claim Reimbursement Statement (PCRS) - Paid](file:///C:\Users\C337799\Downloads\CMS-PRD1-112392).   * **If payment is denied**, the PCRS will indicate the reason for denial and a notice of denial will be mailed with appropriate appeal information.   See sample: [MED D - Prescription Claim Reimbursement Statement (PCRS) - Denied](file:///C:\Users\C337799\Downloads\TSRC-PROD-027696).  **Note:** If a claim receives a [Manual Reject Letter (MRL)](file:///C:\Users\C337799\Downloads\CMS-PRD1-112393), no PCRS will be generated. The Notice of Denial will explain the reason for the denial. |
| **6** | Set beneficiary expectations by providing them with the information in the [Turn Around Times (TAT) for Paper Claims](#_Turn_Around_Times) section. |

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| Additional Paper Claim Requirements |
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To submit a Paper Claim, members should complete a Prescription Drug Claim Form and provide a detailed pharmacy prescription receipt (refer to the [Submitting Paper Claims](#_Submitting_Paper_Claims) section above). Some claim types also have additional Paper Claim requirements.

* [Multi-Ingredient Compound Prescription Claims](#MultiIngredientCompoundRxClaims)
* [Coordination of Benefits (COB) Claims](#COBClaims)
* [Overpayments/Alternate Insurance Paid in Error](#Overpayments)
* [Nursing Home Claims](#NursingHomeClaims)

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| **Paper Claim Type** | **Other Requirements** |
| **Multi-Ingredient Compound Prescription Claims** | For Multi-ingredient compound, two forms will be needed:   * MED D standard [paper claim form](#_Prescription_Drug_Claim_1) - provides the beneficiary information. * [Compound prescription form](file:///C:\Users\c071417\Downloads\CMS-PRD1-065609) - includes all of the ingredients listed separately, with metric quantity and cost for each.   + This form should be filled out by the pharmacy to ensure accuracy.   If the member does not have the necessary forms, CCR will submit a Support Task for the Compound prescription form using the **Create a Support Task** button:   * **Task Type:**  Fulfillment * **Type of Form:**Claim Form * **Compound Form?** Yes * **Note:**Specify that a Compound Prescription form is needed.   **Note:** When the CCR requests the form for a compound prescription, a MED D standard claim form will be mailed in addition to this form. The beneficiary will automatically get both with the one request. The CCR does not need to submit two separate requests.  **Each ingredient used to make up the compound must be listed separately and noted on the Claim Form. In addition, totals must match the pharmacy prescription receipt.**  For Assistance, refer to [Compass - Create Support Task](C:\\Users\\C337799\\Downloads\\TSRC-PROD-050031) or [Compass - Member Resource Orders, Fulfillment Support Tasks, and Statement of Cost (SOC) Requests](file:///C:\Users\C337799\Downloads\TSRC-PROD-056893). |
| **Coordination of Benefits (COB) Claims** | In order to take advantage of the COB benefit, the client’s plan design must have coordination of benefits and paper claims provisions.   1. Review the Client Information Form (CIF) in theSource. 2. Advise the beneficiary that they must submit a standard MED D Claim form and at least one of the following:  * Pharmacy receipts indicating other insurance. * Explanation of Benefits from the Primary Insurer * Statement of cost from the primary insurer * Computer generated cost summary from the provider of service which shows the total paid or amount covered/not covered by the Primary Insurer.  1. Confirm with the beneficiary that the documentation they will submit with the MED D Claim form contains the following information:  * Fill Date * NCPDP/NPI number * RX number * NDC number * Quantity/Days Supply * Total Paid amount * Copay amount * Primary Paid * Member name * Member information, member name and DOB or/and ID |
| **Overpayments/Alternate Insurance Paid in Error** | Changes in eligibility/plan benefits may result in claims processing after their coverage effective dates. As a result, the beneficiary may receive a collection letter requesting repayment for claim paid after coverage termination. The beneficiary would then submit to Caremark for manual processing.   1. Advise the beneficiary that they must submit a standard MED D Claim form and at least one of the following:  * Pharmacy receipts indicating other insurance. * Letter requesting repayment for claim paid after coverage termination. * Statement of cost from the previous insurer. * Computer generated cost summary from the provider of service which shows total paid, or amount covered/not covered, and the copay amount the beneficiary paid with other insurance.  1. Confirm with the member that the documentation they will submit with the MED D Claim form contains the following information:  * Fill Date * NCPDP/NPI number * RX number * NDC number * Quantity/Days Supply * Total Paid amount * Copay amount * Primary Paid * Member name * Member information, member name and DOB or/and ID |
| **Nursing Home Claims** | Nursing Home claims are accepted under the Med D Benefit. They must be received within 90 days from the date of service to be processed to the facility for reimbursement.  **Documentation must include the following:**   * Fill Date * Rx number * 11 digit NDC * Drug Name * Quantity * Days Supply * Amount Paid * Subscriber information * Beneficiary name and ID   The fact that the beneficiary resides in a nursing home must be checked off or annotated on the claim form. Nursing Home plan design provisions generally do not have restricted days supply’s etc.  **Note:** In order to assign benefits, the plan member must indicate this on the submitted claim. |

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| Beneficiary Disputes or Questions Reimbursement Amount on Rx |
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Perform the steps below:

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| **Step** | **Action** | | | |
| **1** | Ask the beneficiary which medication they are calling about and confirm the copay amount paid. | | | |
| **2** | Determine: | | | |
| **If the Beneficiary...** | | | **Then...** |
| Paid full price at a retail pharmacy and didn’t show ID card at pharmacy.  **Note:** MED D claims must be within 90 days of the date of fill. | | | CCR will educate the beneficiary on the following:   * Beneficiary must return to filling pharmacy, present ID card, and request to have the claim reversed and resubmitted for the correct co-pay amount.   **CCR Process Note:** CCR should make an outbound call to the pharmacy to provide processing info if the beneficiary does not have their ID card or if the beneficiary presented it, but the claim is still not found on their profile.  **Note:** If pharmacy needs assistance, CCR can provide the following contact the number to the Retail Services (Retail Help Desk) - MED D: 1- 866-693-4620. If pharmacy will not/cannot reprocess, CCR will send paper claim form to beneficiary.  Refer to [MED D - Standard Claim Form - 193491\_Claim Form 15071-MED\_D-0912](file:///C:\Users\C337799\Downloads\CMS-PRD1-112390). |
| Paid full price at a retail pharmacy and has SPAP coverage, but didn’t show SPAP card | | | Refer to [Compass MED D - Handling State Pharmaceutical Assistance Program (SPAP) Calls 062888](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3bc517e5-7747-419a-a106-523403d686dc). |
| Is enrolled in a plan with a Preferred Pharmacy Network but went to a standard pharmacy instead of a Preferred Pharmacy | | | * CCR will educate the beneficiary that they must use a preferred pharmacy in order to receive the lower copay. * Access the CIF for information regarding the Plan’s Preferred Pharmacy Network and provide the beneficiary information regarding participating pharmacies. |
| Plan made an error in calculating beneficiary TrOOP, which caused the beneficiary to pay the incorrect coverage cost share | | | Paper claims scenarios are considered Coverage Determinations, refer to [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals)](file:///C:\Users\C337799\Downloads\TSRC-PROD-061745). |
| **3** | Access:   * Beneficiary’s claim on the **Financial Details** screen in **Compass** to determine the copay amount. * Plan Design section of the CIF and review the copay amount listed in the Copay Matrix. | | | |
| **4** | Determine if the copay amounts listed in Compass and the CIF match: | | | |
| **If...** | **Then...** | | |
| The amounts listed in Compass and the CIF match | CCR will advise the beneficiary the amount was correct and educate the beneficiary regarding their plan design.   * If the beneficiary expresses dissatisfaction about the amount, alternative medications should be offered. If beneficiary declines alternatives, a Tier Exception should be offered, as appropriate.   + Refer to: [Compass MED D - Coverage Determinations and Redeterminations (Appeals)](file:///C:\Users\C337799\Downloads\TSRC-PROD-061745) * If beneficiary expresses dissatisfaction, a grievance should be offered, as appropriate.   + Submit a grievance in Compass by navigating to the Quick Actions panel on the Member Snapshot Landing Page and selecting **Submit New Grievance**. Refer to [Compass MED D - How to File a Grievance in Compass](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81).   **CCR Process Note:** If the beneficiary states they cannot afford their medication refer to the following work instructions:   * For Tiering Exceptions, refer to [Compass MED D - Coverage Determinations and Redeterminations (Appeals)](file:///C:\Users\C337799\Downloads\TSRC-PROD-061745). * For help paying for all medications, refer to:   + [MED D - Low Income Subsidy (LIS) Informational Overview 018616](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=39c4d667-eb19-4bde-9ec0-bdcda34aa0dd)   + [Prescription Financial Assistance for Members](file:///C:\Users\C337799\Downloads\CMS-PCP1-026963) | | |
| The amounts listed in Compass and the CIF do NOT match and CCR is unable to find a reason for copay discrepancy  **Note:** This scenario is subject to 14-day Turn Around Time | Review the CIF to determine if we handle paper claims for the client. | | |
| **If...** | **Then...** | |
| No | Follow process outlined in the CIF. | |
| Yes | Ask the beneficiary if they have picked up and paid for the medication.   * + If **no**, continue research to identify copay discrepancy including reaching out to Senior Team or Supervisor for assistance if needed.   + If **yes**, run a test claim.     - If the claim adjudicates correctly then the CCR should call the Pharmacy and ask them to reverse and reprocess the claim.     - If the test claim does not adjudicate correctly or if the Pharmacy is unable to reverse and reprocess, then CCR to proceed to the next bullet point for direction on how the beneficiary can request a refund.   To request a refund, you must submit a reimbursement request in writing (Paper Claims). A check for any amount due will be issued within 14 days from the day the PBM receives your request in writing.  Refer to the following sections of the document for submission requirements:   * [Prescription Drug Claim Form (Standard)](#_Prescription_Drug_Claim_1) * [Submitting Paper Claims](#_Submitting_Paper_Claims) | |
| The beneficiary requests to appeal the amount reimbursed | Determine if the beneficiary has submitted a paper claim: | | |
| **If...** | **Then...** | |
| Yes | Advise the beneficiary a decision letter will be mailed within 14 days. If reimbursement is due, it will be mailed within 30 days.  Submit the following Support Task:  **Task Type:** Participant Research Request (CRR)  **Notes:** Explain the reason the beneficiary is disputing the amount reimbursed on their claim and note any specific beneficiary requests or information provided by the beneficiary. | |
| No | To request a refund, you must submit a reimbursement request in writing (Paper Claims). A check for any amount due will be issued within 14 days from the day the PBM receives your request in writing.  Refer to the following sections of the document for submission requirements:   * [Prescription Drug Claim Form (Standard)](#_Prescription_Drug_Claim_1) * [Submitting Paper Claims](#_Submitting_Paper_Claims) | |

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| Prescription Drug Claim Form (Standard) |
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Refer to the image of a MED D Standard Paper Claim form: [MED D - Standard Claim Form - 193491\_Claim Form 15071-MED\_D-0912](C:\\Users\\C337799\\Downloads\\CMS-PRD1-112390).

Beneficiaries can obtain claim forms via the following methods:

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| **Platform / Task** | **Navigational Path** |
| **Caremark.com** | **Electronic Submission**   * Some plans allow submission online or through the CVS Caremark app. Refer to [Caremark.com – Submitting Paper Claims Through Desktop/Mobile Site or Mobile App](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=54a38024-1554-4f79-b741-7a24347df7d3). * Electronic Submission requires a form for each claim.   **Note:** Login required. |
| **Customer Care - Compass / Fulfillment** | Refer to [Compass MED D - Member Resource Orders 061924.](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3a2c4b14-9101-4e14-8221-652e4e6b5b8a)  **Note:** Turnaround Time is up to 10 business days to **receive** the requested item. |
| **Customer Care – Compass Support Task** | Check the CIF first to confirm that the plan allows paper claims before sending the Support Task.  **Create Support Task** button.  **Task Type:**  Fulfillment  **Type of Form:**  Claim Form  **Compound Form?** No  For Assistance, refer to [Compass - Create a Support Task](file:///C:\Users\C337799\Downloads\TSRC-PROD-050031) or [Compass - Member Resource Orders, Fulfillment Support Tasks, and Statement of Cost (SOC) Requests](file:///C:\Users\C337799\Downloads\TSRC-PROD-056893).  **Notes:**   * This task should only be used if the order fulfillment button is not allowing the CCR to place the request. * Turnaround Time is up to 10 business days to **receive** the requested item. |
| **Multi Ingredient/Compound** | Sample [Compound Prescription Paper Claim Form](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4551aa74-d56c-4466-89ae-1d2d4ffd9366).    A fulfillment support task must be submitted.  **Task Type:**  Fulfillment  **Type of Form:**  Claim Form  **Compound Form?** Yes  Refer to [Compass MED D - Member Resource Orders 061924](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3a2c4b14-9101-4e14-8221-652e4e6b5b8a). |

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| Paper Claim Viewer in Compass |

Follow the steps below to view Paper Claims:

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| **Step** | **Action** | |
| **1** | From the **Quick Action** panel on the Claims Landing Page, click the **Paper Claim View** hyperlink.        **Result:**  MedForce screen displays. | |
| **2** | Review the information displayed on the MedForce screen.        **Note:**To narrow results, the following fields can be adjusted:   * **Age from Received:**  Drop-down list of options (Days from the date the claim was received)   + Blank   + 1-3 days   + 4-6 days   + 7-10 days   + 11-14 days   + 15 or more days * **Age from Completed:**  Drop-down list of options (Days from the date when claim was completed)   + 1-30 days   + 31-45 days   + 46-60 days   + 61-90 days   + Greater than 90 days * **Claim Status:** Drop-down list of options (Received, In Process, QA, Other, Completed)   + Received   + In Process   + QA   + Other   + Completed * **Filter:**  Input any information found in the fields below, such as the Image number. | |
| **3** | Select the **Document** icon (lower right side of screen).        **Result:**  Displays the Coversheet and anything else the member sent to us.        Use the following buttons to navigate:   Navigates to the first page of the claim   Navigates one-page back   Navigates one-page forward   Navigates to the last page of the claim    **Example:**  Other page examples that were included in the paper claim request: | |
| **4** | Select the **Form** icon (lower right side of screen).        **Result:**  The member’s Overview Details screen. | |
| **5** | After reviewing the Paper Claim information available from both the **Document**and **Form** icons, proceed as follows:    **Notes:**   * The member can call Customer Care and submit a task to follow-up on missing or incorrect information. This task will be submitted through Salesforce by SRT. * When you are finished utilizing the Paper Claim Viewer, it will need to be closed manually.     **Turn Around Time:**  Refer to [Turn Around Times (TAT) - Paper Claims](#_Turn_Around_Times) section below. | |
| **If...** | **Then...** |
| The member submitted the correct information according to MedForce but claim status is rejected. | Advise member of the reason for the rejected claim. |
| The member did not submit the correct information according to MedForce | Notify the member what they need and have them resubmit their request.  Follow the process outlined in the [Submitting Paper Claims](#_Submitting_Paper_Claims) section.    When resubmitting a paper claim.  The member’s new paper claim request is linked to their previous paper claim request/previous documents. |
| There is an error in the claim according to MedForce | Reach out to the **Senior Team** to submit a SalesForce case to correct the issue (rather than having the member completely resubmit the claim). |
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| Dismissal of Paper Claim |
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Perform the steps below:

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| **Step** | **Action** | | |
| **1** | View the [Dismissal Notice](file:///C:\Users\C337799\Downloads\TSRC-PROD-048450) in [Paper Claim Viewer in Compass](#_Paper_Claim_Viewer) to determine the reason for the dismissal. | | |
| **2** | Advise the beneficiary on the reason the case was dismissed, including what specific information was missing. | | |
| **3** | Determine the reason the beneficiary is calling: | | |
| **If calling to...** | **Then...** | |
| Submit required documentation | Advise the beneficiary to resubmit **ALL** required documentation within 60 days of the date of the dismissal notice if they would like to appeal or within 180 days to vacate the dismissal. Vacating involves rescinding the original decision to dismiss and processing the claims, if all the information needed to process the claim is provided. The beneficiary will receive a vacate letter if this is the case.  **Note:** Any documentation received outside of the 60-day timeframe (BUT within 180 days) will be reviewed as a new Coverage Determination. | |
| Appeal Dismissal | 1. Refer to the CIF for client’s specific appeals process. 2. Advise the beneficiary to resubmit **ALL** required documentation for processing. | |
| **If...** | **Then...** |
| All documentation is submitted. | The request will be reviewed again for reimbursement. The beneficiary will receive an approval to vacate letter. |
| Any documentation is missing | The request will be denied, and the beneficiary will receive a denial notice.  **Note:** If the appeal was denied, direct the beneficiary to the Independent Review Entity for additional processing and determination. |

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| Scenario Guide |

Refer to the following scenarios as needed:

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| **Scenario** | **Action/ Requirements** |
| Additional information is required to process the claim | * The beneficiary will need to resubmit the paperwork with the missing information. * Inform the caller that our processing time will begin once we receive the resubmitted claim.   **Note:** Refer to the [Turn Around Times (TAT) - Paper Claims](#_Turn_Around_Times) section of this document for more information. |
| Claim was processed incorrectly | Research the cause of the packet rejection in [Paper Claim Viewer in Compass](#_Paper_Claim_Viewer) and advise the caller to resubmit with the appropriate information. |
| If the beneficiary disagrees with the reimbursement amount | Refer to the [Beneficiary Disputes or Questions Reimbursement Amount on Rx](#_Beneficiary_Disputes_Amount) section of this document. |
| Online through Desktop/Mobile Site or Mobile App | Refer to [Caremark.com – Submitting Paper Claims Through Desktop/Mobile Site or Mobile App (Medicare D)](file:///C:\Users\C337799\Downloads\TSRC-PROD-046782).  **Note:** Only Select MED D clients can submit paper claims using the online tool. |
| Submitting Without a Paper Claim form | Icon_-_Important_Information If the beneficiary cannot access a **Prescription Drug Claim Form** or does not have access to a computer/mobile device, they can:   * Provide the following **required** information on a blank piece of paper:   + Primary Member ID#   + Member Name (and DOB or ID# if different from cardholder)   + Member Address * Submit the following information:   + The required information on a blank piece of paper   + A **detailed pharmacy prescription receipt** along with any discount card that was used and the amount of the discount.     - * A detailed pharmacy prescription receipt includes the following information:         + Rx Number         + NPI/NCPDP Number         + NDC Number         + Metric Qty/Days Supply Number         + DAW (if applicable)         + Dispensed Quantity         + DEA/NPI Number         + Date of Fill         + Cost of Medication   **Notes:**   * If the days’ supply is not listed on the receipt from the pharmacy, tell the plan beneficiary to contact his/her local pharmacy or pharmacist to ask for the information. Tell the plan beneficiary to either:   + Ask the local pharmacy to print a new receipt that includes the days’ supply.   + Ask the local pharmacy to print a report that includes the days’ supply information; or handwrite the days’ supply on the original receipt. * Claims that do not include the days’ supply will be returned to the plan beneficiary with a letter explaining how to obtain the days’ supply from the pharmacy. The days supply is necessary to ensure appropriate benefits consideration. Once the days’ supply has been obtained, the plan beneficiary should resubmit the claim form, a copy of the letter and the receipt(s) back to the PBM at the appropriate post office box.   Proceed to Step 3 of [Submitting Paper Claims](#_Submitting_Paper_Claims). |

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| Turn Around Times (TAT) - Paper Claim |
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Turnaround time is based on CMS guidelines.

* Paper Claims are processed within **14 calendar days**, if submitted for the first time.
* If an Appeal is received, the decision will be mailed to the beneficiary within **14 calendar days**, and payment within **30 calendar days**, if payment is due.

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| **If claims are…** | **Then…** |
| **Eligible** | Documentation will display in the system. |
| **Not Eligible** | No documentation will display in the system. |
| **Processed** | Beneficiary will receive either a reimbursement check or a Prescription Claim Reimbursement Statement (PCRS) within **14 calendar days of receipt of initial request**. |

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| Related Documents |

* Grievance Standard Verbiage (for use in Discussion with Beneficiary) section in [MED D - Grievances Index](file:///C:\Users\c071417\Downloads\TSRC-PROD-007931)
* [MED D - CMS Criteria for Using out of Network Pharmacies](file:///C:\Users\C337799\Downloads\TSRC-PROD-010079)
* [MED D - Paper Claim - Reject Reason Codes](file:///C:\Users\C337799\Downloads\TSRC-PROD-010081)

**Parent SOP:**

* CALL-0048: [Medicare Part D Customer Care Call Center Requirements-CVS Caremark Part D Services, L.L.C.](https://policy.corp.cvscaremark.com/pnp/faces/SecureDocRenderer?documentId=CALL-0048&uid=pnpdev1)
* CALL-0011: [Authenticating Caller](https://policy.corp.cvscaremark.com/pnp/faces/DocRenderer?documentId=CALL-0011)

**Abbreviations/Definitions:** [Abbreviations / Definitions](file:///C:\Users\C337799\Downloads\CMS-2-017428)

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