

## PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. Please print clearly. Additional information and instructions on back, please read carefully.

Member information  RxGroup (see ID card)	Mambar ID (soo ID card)						
rxdioup (see ib cara)	Member ID (see ID card)						
Last name	First name	MI					
Mailing street address		Apt. #					
City	State	ZIP					
Prescription is for O Self O Spouse O Dependent	Date of Birth (mm/d	d/yyyy)					
Custodial parent information							
For reimbursement requests from a parent for a child (under the age of 1. Parent is not enrolled in the same Group Health plan as the chi 2. Parent does not reside in the same household as the subscriber If your child is covered under two or more health plans, state law	d under the child's Group Health plan determines the order of benefits for pr	ocessing claims.					
Legal custodian's name	Legal custodian's contact pho	ne					
Custodian requesting reimbursement name	Custodian requesting reimbursement contact phone						
Address payment is to be mailed to							
Physician and pharmacy information							
Prescribing physician name	Dispensing pharmacy nam	e					
Prescribing physician phone number with area code	Dispensing pharmacy phone number with area of	code					
<b>Reason for request</b> Select appropriate options for you	r request						
I I did not use my Prescription Drug ID card	☐ My primary coverage is with a						
I I used a non-participating pharmacy (please explain)	(coordination of benefits claim for details)	n; see section C on back					
	O I am submitting an from another Healtl	Explanation of Benefits (E					
I filled a compound prescription (your pharmacist must	O I am submitting a co						
complete section B on the back of this form)	☐ I was waiting for a drug appro						
I purchased medication outside of the United States	☐ I was retroactively enrolled wit						
Country	My pharmacy billed the wrong plan						
Currency used	☐ Other (please explain)						
	<b>—</b> Оптет (ртеазе ехртант)						
Acknowledgement							
I certify that the medication(s) for which reimbursement is	requested were received for use by	the nationt above					
i cerniv inal the medicalion(s) for which reimpursement is							
and that I (or the patient, if not myself) am eligible for pres received were not for treatment of an on-the-job injury. I re assignment of these benefits to a pharmacy or any other p	ecognize reimbursement will be pai						



## Instructions for submitting form

- 1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in Section A (below). If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
- 2. Read the Acknowledgement (section 5) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
- 3. Send completed form with pharmacy receipt(s) to: OptumRx Claims Department, PO Box 650629, Dallas, TX 75265-0629

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Reimbursement is not guaranteed. Claims are	subject to your pla	an's limi	ts, €	exclu	ision	s and	prov	isions	5.			
Section A – Pharmacy receipts fo Use the following checklist to ensure your rec □ Date prescription filled □ Name and address of pharmacy □ Prescribing physician name or ID number		nation Code (	ND(	C) n		•			riptio	t request: on number (	Rx numb	er)
Section B – Pharmacy information (Pharmacist must complete and sign)  • List VALID 11 digit NDC number (highest to lo	owest	prescrip	otio	ns C	NLY,	)		ate illed			Days Supply	
cost) in the box at right. Include EACH ingred used in the compound prescription.		VALID 11 digit NDC#				DC#				uantity*	Ingred Cost <sup>†</sup>	dient
<ul> <li>For each NDC number, indicate the metric quexpressed in the number of tablets, grams, moreams, ointments, injectables, etc.</li> </ul>												

•	Indicate	tha	TOTAL	amount	naid	hy tha	nationt
•	indicate	me	TUTAL	amount	pald	by the	patient.

- Receipt(s) must be provided with this claim form.
- \* Individual quantities must equal the total quantity.
- <sup>†</sup> Individual ingredient costs plus compounding fees must be equal to the total ingredient costs.

		Filled					ille	a	Supply					
VALID 11 digit NDC#									Quantity*		Ingredient Cost <sup>†</sup>			
Compounding Fee														
Total														

## Section C - Coordination of benefits

Signature of Pharmacist

You must submit claims within one year of date of purchase or as required by your plan.

When submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare: If you have not already done so, submit the claim to the Primary Plan or Medicare. Once you receive the EOB, complete this form, submit the pharmacy receipts, and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the Primary Plan or Medicare.

**When submitting a copay receipt:** If your Primary Plan requires you to pay a copayment or coinsurance to the pharmacy, then no EOB is needed. Just complete this form and submit the pharmacy receipts showing the amount you paid at the pharmacy. These receipts will serve as the EOB.

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.\*

- \*Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.
- \*California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.



The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

請注意:如果您說中文 (Chinese),公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通,我们提供一些免费服务,例如用其他语言书写的信件或大字体。您也可以 要求与口译员对话。欲寻求帮助,请拨打您的 ID 卡上列出的免费电话号码。