

MAPD 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 ID (see ID card	tion								
	d)	H	lealth Plan Name						
Group/Employer Name		F	lealth Plan State						
Last Name		F	irst Name	MI					
Mailing Street Address				Apt. #					
City	State	ZIP	Date of Birth (mm/dd/yyyy) Gender	OM OF					
Physician and Pha	rmacy Informa	ation							
Prescribing Physician N	ame		Dispensing Pharmacy Name						
Prescribing Physician Ph	none Number with	Area Code	Dispensing Pharmacy Phone Number with Area Code						
Reason for Reque									
O I could not get driving distanc O A non-networ outpatient sur O I was evacuate	ng pharmacy for or de my plan's service my medication in de or a network mai k pharmacy located gery or other outpa d or displaced from	ne of the following area and needed a timely manner of a service pharmacy of within a care institution facility) disposition my residence due armacist must compared and armacist must compared and needed.	my medication but cour from either a network p sy. titution (emergency de- ensed my medication w to a state or federally co- applete Section B on the	Id not access a network pharmacy. charmacy located within a reasonable partment, provider based clinic, while I was a patient. declared disaster or health emergency. back of this form).					

I certify that the patient for whom this claim is made is covered in this prescription drug program and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

Member or Authorized Representative Signature

NOTE: If form is completed and signed by an Authorized Representative rather than the member, an Authorization of Representation (AOR) must accompany the request or Power of Attorney (POA) must be on file with the plan.



Date

Instructions for Submitting Form

- 1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipt(s) must contain the information in Section A (below). If you do not have pharmacy receipt(s), ask your pharmacy to provide them to you.
- 2. Read the Acknowledgement (Section 4) 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, P.O. Box 29045, Hot Springs, AR 71903.

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.

Section A – Pharmacy Receipt(s) for Reimbursement

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LISE the tollowing	checklist to ensure	vour receint(s) hav	<i>i</i> e all information	reallired for V	<i>I</i> OHR REIMHHRSEMEN	t reallest:
OSC LITE TOHOWITH	CHECKIIST TO CHISTIC	your receipt(3) riav		required for y	our remindursement	LICGUEST

O Date prescription filled

- O National Drug Code (NDC) number
- O Prescription number (Rx number)

- O Name and address of pharmacy
- O Name of drug and strength
- O Quantity

- O Prescribing physician name or ID number
- O Amount paid by member

Section B – Compound Information (for compound prescriptions ONLY)

(Pharmacist must complete and sign)

- List VALID 11 digit NDC number (highest to lowest cost) in the box at right. Include EACH ingredient used in the compound prescription.
- For each NDC number, indicate the metric quantity expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL amount paid by the patient.
- Receipt(s) must be provided with this claim form.
- * Individual quantities must equal the total quantity.
- [†] Individual ingredient costs plus compounding fees must be equal to the total ingredient costs.

Rx#									ille			Sı	ays 			
VALID 11 digit NDC#										Quantity*			Ingredient Cost [†]			
Compounding Fee											>	<				
Total																

Section C - Coordination of Benefits

You must submit claims within 36 months 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 receipt(s), 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 receipt(s) showing the amount you paid at the pharmacy. This receipt(s) will serve as the EOB.

