

PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form

RxGroup (see ID card)	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	Gender O M O F Date of Birth (mm/dd/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 characteristic content of the same household as the subscribe of the same household as the s	nild er under the child's Group v determines the order of Legal custodian's conta	Health plan be the benefits for processing claims. ct phone					
Custodian requesting reimbursement name	Custodian requesting re	eimbursement contact phone					
Address payment is to be mailed to							
Physician and Pharmacy Information							
Prescribing physician name	Dispensing pharmacy name						
Prescribing physician phone number with area code	Dispensing pharmacy phone number with area code						
Reason For Request							
Select appropriate options for your request: ☐ I did not use my Prescription Drug ID card ☐ I used a non-participating pharmacy (please explain)	☐ My primary coverage is with another insurance carrier (coordination of benefits claim; see section C on back for details)						
☐ I filled a compound prescription (your pharmacist must complete section B on the back of this form) ☐ I purchased medication outside of the United States Country Currency used	□ I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare □ I am submitting a copay receipt □ I was waiting for a drug approval □ I was retroactively enrolled with the plan □ My pharmacy billed the wrong plan □ Other (please explain)						
Acknowledgement							
Leastify the at the amount is at any (a) for you leight waited by we are any in		ed for use by the patient above, and that					
(or the patient, if not myself) am eligible for prescription d treatment of an on-the-job injury. I recognize reimbursempharmacy or any other party is void.							

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, P.O. Box 29044, 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 quaranteed. Claims are subject to your plan's limits, exclusions and provisions

Section A – Pharmacy Receipts fo	or Reimbursen	nent					
Use the following checklist to ensure your rec ☐ Date prescription filled ☐ Name and address of pharmacy ☐ Prescribing physician name or ID number	eipts have all inforr National Drug Name of drug		ription number (Rx number)				
Section B – Pharmacy Information (Pharmacist must complete and sign)	on (for compound	prescrip	otions ONLY)				
List VALID 11 digit NDC number (highest to lowest cost) in the box at right. Include EACH ingredient		Rx#		Date Filled		Days Supply	
 used in the compound prescription. For each NDC number, indicate the metric quexpressed in the number of tablets, grams, moreams, ointments, injectables, etc. 			VALID 11 digit NDC#		Quantity*	Ingred Cost [†]	lient
• Indicate the TOTAL amount paid by the patie	ent.						
• Receipt(s) must be provided with this claim for	orm.						
* Individual quantities must equal the total qu † Individual ingredient costs plus compoundin must be equal to the total ingredient costs.	•						
X		Compounding Fee					
Signature of Pharmacist				Total			

Section C – Coordination of Benefits

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.

Total

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.



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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。