

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 Info	l l				
RxGroup (see ID c	ard)	1	Member ID (see ID card)		
Last Name		F	irst Name	MI	
Mailing Street Ad	dress			Apt. #	
City	State	ZIP	Prescription is for O Self O Spouse O De	Gender ependent OM OF	
			Date of Birth	_]/[]/[]/[
-	Pharmacy Inform	nation			
Prescribing Physician Name			Dispensing Pharmacy Name		
		Prescribing Physician Phone Number with Area Code		Dispensing Pharmacy Phone Number with Area Code	
Reason For Re	equest		Dispensing Pharmacy P	hone Number with Area Cod	
Reason For Re	equest options for your reque	est:	Dispensing Pharmacy P	hone Number with Area Coc	
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I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: _____

Date: ___



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 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 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 guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Section A – Pharmacy Receipts for Reimbursement

Use the following checklist to ensure your receipts have all information required for your reimbursement request:

- O Date prescription filled
- O National Drug Code (NDC) number

- O Name and address of pharmacy
- O Name of drug and strength
- O Prescription number (Rx number) O Quantity

O Prescribing physician name or ID number

Section B – Pharmacy 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#	Date Filled		Days Supply				
VALID 11 digit NDC#	Quantity*	Ingredient Cost [†]					
Compounding Fee							
Total							

X

Signature of Pharmacist

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.

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.

