



Prescription Drug Program Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription label receipt(s).**

Cash register and credit card receipts alone are not acceptable as proof of purchase.

Reimbursement is not guaranteed.

Claims will be subject to limitations, exclusions and other provisions of the Plan Benefit.

Patient Information (one form per patient)

Health Plan (Insurance) Name *(please print)*

Name *(Last Name, First Name, MI)*

Birth Date

I.D. Number

Mailing Address *(Number, Street, City, State & Zip Code)*

Prescribing Physician's Name

Physician's Telephone Number

Reason For Request

(At least one must be checked)

- | | |
|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Out of Area emergency medication | <input type="checkbox"/> Compound medication |
| <input type="checkbox"/> Non-emergency medication/vacation request | <input type="checkbox"/> Member not found in pharmacy system |
| <input type="checkbox"/> No identification card or identification number available | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Coordination of Benefits (From Primary Insurance – complete section below) | |

Coordination of Benefits

(If your primary insurance has already paid for the attached prescription, please complete this section.)

Primary Health Plan/Insurance Company Name _____

Primary Member/Subscriber's Name *(Last Name, First Name, MI)* _____

Primary Member/Subscriber's ID _____

I certify that the patient for whom this claim is made is a covered person 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 workers 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.

X _____
Member's/Subscriber's Signature

Date

Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.

- | | |
|------------------------------------|---------------------------------------|
| • Pharmacy Name | • Prescription number and date filled |
| • Drug name, strength and quantity | • Member paid expense |
| • Prescribing physician's name | |

The claim(s) will be returned if the member/subscriber's signature is not present.

Please mail label receipt(s) and this completed form to:

**OptumRx
P.O. Box 29044
Hot Springs, AR 71903**

Reimbursement and correspondence will be issued to the primary member/subscriber.