OPTUMRx®

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.**

1 Member Information

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)* ___/___/____

2 Physician and Pharmacy Information

Prescribing Physician Name | Dispensing Pharmacy Name

Prescribing Physician Phone Number with Area Code | Dispensing Pharmacy Phone Number with Area Code

3 Reason For Request

Select appropriate options for your request:

- O I did not use my Prescription Drug ID card
- O I used a non-participating pharmacy *(please explain)* _____
- O I filled a compound prescription *(your pharmacist must complete section B on the back of this form)*
- O I purchased medication outside of the United States
  Country _____ Currency used _____
- O My primary coverage is with another insurance carrier *(coordination of benefits claim; see section C on back for details)*
  - O I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare
  - O I am submitting a copay receipt
- O I was waiting for a drug approval
- O I was retroactively enrolled with the plan
- O My pharmacy billed the wrong plan
- O Other *(please explain)* _____

4 Acknowledgement

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 Name and address of pharmacy
- O Prescribing physician name or ID number
- O National Drug Code (NDC) number
- O Name of drug and strength
- O Prescription number (Rx number)
- O Quantity

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.