

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.

	Information				
Member ID	(see ID card)		ŀ	Health Plan Name	
Group/Emp	loyer Name		ŀ	Health Plan State	
Last Name			F	First Name	MI
Mailing Stre	eet Address				Apt. #
City		State	ZIP	Date of Birth (mm/dd/yyyy) Gender	O M O F
Physiciar	n and Pharma	cy Informa	ation		
Prescribing	Physician Name			Dispensing Pha	rmacy Name
Prescribing	Physician Phone N	Number with	Area Code	Dispensing Pha	rmacy Phone Number with Area Code
O I used a not O I tr O I cc dri O A r our O I was waitir O I was retroat O My pharma O Vaccine and O Vaccine and O I was and O Vaccine and O I was retroat O My pharma O Vaccine and O I was retroat O My pharma	ould not get my me ving distance or a non-network phare tpatient surgery of vas evacuated or de mpound prescript of coverage is with	armacy for or plan's service nedication in a network mai macy located or other outpaisplaced from ion (your phananother insurexplanation of Name:pay receipt. roval. with the plan. In plan. In filled at:	ne of the following area and needed a timely manner of the service pharmals within a care instituted facility) display my residence durmacist must contrance carrier (coo.	I my medication but cou from either a network p cy. stitution (emergency de pensed my medication v e to a state or federally of mplete Section B on the	declared disaster or health emergency. back of this form). aim, see Section C on back for details).
• V	accine prescriptio	n filled at:	O Pharmacy	O Physician's office	

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

Use the following checklist to ensure your receipt(s) have all information required for your reimbursement request:

O Date prescription filled

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

- O Name and address of pharmacy O Prescribing physician name or ID number
- O Name of drug and strength O Amount paid by member
- O Quantity

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	x#							ille		5			ays upply			
VALID 11 digit NDC#											Quantity*			Ingredient Cost [†]		
Compounding Fee											\supset	<				
 Total																

Signature of Pharmacist

X

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.

