

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 Inforn	nation						
RxGroup (see ID car	rd)	N	Member ID (see ID card)				
Last Name		F	irst Name	MI			
Mailing Street Addr	ress			Apt. #			
City	State	ZIP	Prescription is for O Self O Spouse O Dep	Gender pendent O M O F			
			Date of Birth [<i>y</i> [
	Pharmacy Inforn	nation	Diagramaina Dhaguna ay Ma				
Prescribing Physicial	n Name		Dispensing Pharmacy Na	me			
Prescribing Physicia	n Phone Number witl	n Area Code	Dispensing Pharmacy Phone Number with Area Code				
Select appropriate of O I did not use my Pre							
	options for your requ						
O I used a non-partici	,						
			nplete section B on the back of t	his form)			
O I purchased medica			inpiete section b on the back of t	nis romny			
Country			Currency used				
O I was waiting for a			carrency useu				
O I was retroactively e							
O My pharmacy billed	•						
O Other (please explain	• •						
O other (prease exprais							
Acknowledgen	nent						
and that I (or the pa received were not fo	atient, if not myself) ar	m eligible for presci -the-job injury. I rec	equested were received for use by ription drug benefits. I also certify cognize reimbursement will be pai rty is void.	that the medications			
Signature:			r)ate:			



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.

O Name of drug and strength

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 Prescription number (Rx number)

Days

- O Name and address of pharmacy
- O Prescribing physician name or ID number

O Quantity

Date

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.

KX#							F	ille	d		S	upply
VAI	VALID 11 digit NDC#								Quantity* Ingrediction Cost [†]		Ingredient Cost [†]	
Compounding Fee									>>	<u> </u>		
 Total												

X _____ Signature of Pharmacist

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.

