OPTUMRx®

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.**

1 Member Information

Member ID *(see ID card)*

Health Plan Name

Group/Employer Name

Health Plan State

Last Name

First Name

MI

Mailing Street Address

Apt. #

City

State

ZIP

Date of Birth *(mm/dd/yyyy)* __ __ / __ __ / __ __ __ __

Gender O M O F

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 for one of the following reasons:
  - O I traveled outside my plan's service area and needed my medication but could not access a network pharmacy.
  - O I could not get my medication in a timely manner from either a network pharmacy located within a reasonable driving distance or a network mail service pharmacy.
  - O A non-network pharmacy located within a care institution (emergency department, provider based clinic, outpatient surgery or other outpatient facility) dispensed my medication while I was a patient.
  - O I was evacuated or displaced from my residence due to a state or federally declared disaster or health emergency.
- O I filled a compound prescription *(your pharmacist must complete Section B on the back of this form).*
- 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.
    Primary Health Plan Name: ______________________________
  - 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 Vaccine and/or vaccine administration
  - • Vaccine prescription filled at: O Pharmacy O Physician's office
  - • Vaccine administered by: O Pharmacy O Physician's office
  - • Applicable to cost of claim (select all that apply): O Administration cost O Vaccine cost
- O Other *(please explain)* ______________________________

4 Acknowledgement

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.

X ______________________________ ______________

Member or Authorized Representative Signature **Date**

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.

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:

- ○ Date prescription filled
- ○ Name and address of pharmacy
- ○ Prescribing physician name or ID number
- ○ National Drug Code (NDC) number
- ○ Name of drug and strength
- ○ Amount paid by member
- ○ Prescription number (Rx number)
- ○ 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#		Date Filled		Days Supply	

	VALID 11 digit NDC#	Quantity*	Ingredient Cost†
Compounding Fee		X	
Total			

X ____________________

Signature of Pharmacist

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.