Optum Rx®

Prescription drug program
Medicaid Direct Member Reimbursement Form

Use this form to get refunded if you paid retail cost for your covered prescription drug(s).

You can submit this form for any of these reasons:

- You're a new member and didn't have your prescription ID card.
- Your pharmacy couldn't find your information in the pharmacy system.
- You were discharged from an inpatient facility after service hours.
- Your primary insurance has already paid for the attached prescription (Coordination of Benefits).
- You had an emergency outside of where you live and didn't have your prescription ID card (Provide proof of Urgent Care or Emergency Room Explanation of Benefits).

Read carefully before mailing your completed form.

- You must include the original prescription label receipt(s) and credit card or cash register receipts as proof of purchase.
- Submitting this form doesn't guarantee that you will get paid back.
- Claims will be subject to limitations, exclusions and other provisions of the Plan Benefit.
- Any refund or mailings will be sent to the primary plan member.
- The claim(s) will be returned if the form is not completed and signed by the plan member.

Your receipt(s) must have the following information:

- Pharmacy name
- Drug name, strength and quantity
- Prescribing doctor's name
- Prescription number and date filled
- The amount the member paid for the prescription(s)
- If we can't read your receipts, your payment could be delayed, or you may not get paid back.

Mail the completed form and receipt(s) to:

Optum Rx
P.O. Box 650334
Dallas, TX 75265-0334

Questions?

Call the toll-free Member Services number on your member ID card.

Member information (Please print)

Health plan (insurance) name	Member ID	Date of birth

Last name, First name, MI

Mailing address

Prescribing doctor's name	Prescribing doctor's phone number

Reason for request (At least one reason must be selected)

- ☐ I'm a new member and didn't have my prescription ID card.
- ☐ My pharmacy couldn't find my information in the pharmacy system.
- ☐ I was discharged from an inpatient facility after service hours.
- ☐ I had an emergency outside of where I live and didn't have my prescription ID card (Provide proof of Urgent Care or Emergency Room Explanation of Benefits).
- ☐ My primary insurance has already paid for the attached prescription (See Coordination of Benefits section below).

Coordination of Benefits

Only fill out this section if your primary insurance has already paid for the attached prescription.

Primary health plan/Insurance company

Primary member name (Last name, First name, MI)

Primary member ID	Date

By signing this form I'm confirming that:

- The member for whom this claim is made is covered by this prescription drug program.
- This prescription is only for the named member.
- The claims I submitted for payment aren't eligible for payment under a no-fault automobile or workers' compensation insurance program.
- I authorize the release of all information for this claim to the plan administrator, underwriter, sponsored policy holder and/or employer.

Signature	Date

Please keep a copy of this form and receipts for your records.

United Healthcare Community Plan

UnitedHealthcare Community Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-414-9025**, TTY/PA RELAY **711**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-414-9025**, TTY/PA RELAY **711**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-414-9025**, TTY/PA RELAY **711**.