



# Prescription Drug Plan Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription label receipt(s).**

**Cash register and credit card receipts alone are not acceptable as proof of purchase.**

**Reimbursement is not guaranteed.**

Claims are reviewed, subject to limitations, exclusions and other provisions of the Plan Benefit.

### Patient Information (Complete one form per member)

Health Plan/Insurance Name & State <i>(please print)</i>		Group Employer/Name
Name <i>(Last Name, First Name, Middle Initial)</i>		I.D. Number
Mailing Address <i>(Number, Street, City, State &amp; Zip Code)</i>		Birth Date
Prescribing Physician's Name	Physician's DEA or NPI number. <i>(Obtain from physician)</i>	Physician's Telephone Number

### Reason For Request

Write the reason here:

### Coordination of Benefits

*(If your primary insurance has already paid for the attached prescription, please complete this section.)*

**An Explanation of Benefit from the primary insurance must include the dollar amount paid by the primary insurance.**

Primary Health Plan/ Insurance Company Name \_\_\_\_\_

Primary Member/Subscriber's Name *(Last Name, First Name, MI)* \_\_\_\_\_

### Compound Prescriptions Only (Pharmacist must complete and sign)

- List the VALID 11 digit NDC number (highest to lowest cost) in the box at the right for EACH ingredient used for 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 charge (dollar amount) paid by the patient.
- Receipt(s) must be provided with claim form

Rx#	Date Filled	Days' Supply	
<b>Valid 11 digit NDC#</b>			<b>Quantity</b>
<b>Total Quantity</b>			
<b>Total Charge</b>			

### Signature of Pharmacist **X**

I certify that the patient for whom this claim is made is a covered person 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's/Subscriber's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

### Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.

- |                                     |                                       |
|-------------------------------------|---------------------------------------|
| • Pharmacy Name                     | • Prescription number and date filled |
| • Drug name, strength, and quantity | • Member paid expense                 |
| • Prescribing physician's name      |                                       |

**The claim(s) will be returned if the member/subscriber's signature is not present.**

Please mail label receipt(s) and this completed form to:

**OptumRx™  
P.O. Box 29044  
Hot Springs, AR 71903**

Reimbursement and correspondence will be issued to the primary member/subscriber.