OPTUMRx®

PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at the point-of-sale from a participating pharmacy. Complete one form per patient. Additional necessary information and instructions are on the back, please read carefully.

1 Member information

RxGroup *(see ID card)*	Contract ID *(see ID card)*	Telephone #
Last name	First name	MI
Mailing street address		Apt. #
City	State	ZIP
Prescription is for ○ Self ○ Spouse ○ Dependent	Date of Birth *(mm/dd/yyyy)*	

If prescription is for spouse or dependent:

Patient Last Name	Patient First Name	MI	Patient Date of Birth *(mm/dd/yyyy)*

2 Other Insurance Information

Is the patient covered by other health insurance? ○ **YES** ○ **NO** *If yes, complete the following:*	Policy Or Contract Number	Name of Policy Holder	Effective Date

Name and Address of Other Insurance Carrier:

PLEASE ATTACH A COPY OF THE OTHER INSURER'S BENEFIT PAYMENT NOTICE.

3 Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: _____ **Date:** _____

Instructions for submitting form

1. Read the Acknowledgement (section 3) of this form carefully. Then sign and date.
2. Either complete Section A OR attach pharmacy receipts. Print the front and back pages and send completed form to:
   OptumRx Claims Department, PO Box 650334, Dallas, TX 75265-0334.

If submitting a receipt, the receipt provided by the pharmacist must provide the following: Drug Name and Strength, date filled, amount charged and prescription number.

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 – Prescription drugs

It is not necessary to attach receipts if this form is filled out correctly.

Print Numbers Carefully As Shown

1	2	3	4	5	6	7	8	9	0

1	Drug Name and Strength		Date Filled	MONTH	DAY	YEAR	
	Amount Charged		Prescription Number (Rx#)				
2	Drug Name and Strength		Date Filled	MONTH	DAY	YEAR	
	Amount Charged		Prescription Number (Rx#)				
3	Drug Name and Strength		Date Filled	MONTH	DAY	YEAR	
	Amount Charged		Prescription Number (Rx#)				
4	Drug Name and Strength		Date Filled	MONTH	DAY	YEAR	
	Amount Charged		Prescription Number (Rx#)				
5	Drug Name and Strength		Date Filled	MONTH	DAY	YEAR	
	Amount Charged		Prescription Number (Rx#)				

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.

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