

MEDICARE PART D CLAIM 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 Information	on				
Member ID (see ID card)			Health Plan Name		
Group/Employer Name	<u> </u>		Health Plan State		
Last Name			First Name	MI	
Mailing Street Address				Apt. #	
City	State	ZIP	Date of Birth (mm/dd/yyyy)		
Physician and Phari	macy Information	on			
Prescribing Physician N		1	Dispensing Pharmacy	Name	
Prescribing Physician P	hone Number with	n Area Code	Dispensing Pharmacy	Phone Number with Area Co	
Reason for Reques	 t				
Select appropriate opti	ons for your reque	est:			
I I did not use my prescr					
l used a non-participat	ing pharmacy for o	one of the follo	wing reasons:		
			ded my medication but could not	access a notwork pharmacy	
☐ I could not ge	t my medication in	i a timely manr	ner from either a network pharma	acy located within a reasona	
	ce or a network ma				
□ A non-networ	k pharmacy locate	ed within a care	e institution (emergency departme	ent, provider based clinic,	
outpatient sur	gery or other outp	patient facility)	dispensed my medication while I	was a patient.	
□ I was evacuate	ed or displaced from	n my residence	due to a state or federally declare	d disaster or health emerger	
	'	•	complete Section B on the back o	9	
			•		
			coordination of benefits claim, se		
□ I am submittin	ig an Explanation of	of Revetits (FO	B) from another health plan or M	edicare.	
Primary Health					
	ng a copay receipt.				
I I was waiting for a dru	g approval.				
I I was retroactively enro	olled with the plan.				
I My pharmacy billed the					
I Vaccine and/or vaccine	• .				
	cription filled at:	O Pharmacy	O Physician's office		
Vaccine presi Vaccine adm	inistered hv	O Pharmacy	O Physician's office		
	o cost of claim (sele			Vaccine cost	
		сстан шатарр	iy/. 🗖 Administration Cost 🔲	vaccine cost	
1 Other (please explain)					
Acknowledgement	, •				
Legality that the patient	t for whom this cla	im is made is co	overed in this prescription drug pro	ogram and that the prescript	
is for the sole use of the	e named patient. I	also certify that	t the claim(s) being submitted for	payment are not eligible	
for payment under a no	o-fault automobile	or worker's cor	npensation insurance program. I a	ilso authorize release of all	
information pertaining	to this claim(s) to t	he plan admini	strator, underwriter, sponsored po	licy holder, and/or employer.	
v					
X Mambar or Author	uinad Danus aanta	this Clauseties		Data .	
Member or Author	•	•		Date	
NOTE: If form is com	ipleted and signed	l by an Authori	zed Representative rather than		

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.

ORX5262E-UHCMRM_191009 SS_CFOR5262A_UHCMRM



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, PO Box 650287, Dallas, TX 75265-0287.

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 you	r plan's limi	ts, exclusions and	provisions	, , , , , , , , , , , , , , , , , , , ,				
Section A – Pharmacy Receipts for Reimburs	sement							
Use the following checklist to ensure your receipts have all information required for your reimbursement request: ☐ Date prescription filled ☐ National Drug Code (NDC) number ☐ Name and address of pharmacy ☐ Name of drug and strength ☐ Quantity ☐ Prescribing physician name or ID number								
Section B – Pharmacy Information (for compose (Pharmacist must complete and sign)	und prescrip	otions ONLY)						
 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. 			Date Filled		Days Supply			
		11 digit NDC#	Quantity* Ingredient Cost [†]		lient			
• 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. 								
v		Compou	nding Fee					
Signature of Pharmacist	_		Total					

Section C – Coordination of Benefits

You must submit claims within one year 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 receipts, 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 receipts showing the amount you paid at the pharmacy. These receipts will serve as the EOB.



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The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

請注意:如果您說中文 (Chinese),公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通,我们提供一些免费服务,例如用其他语言书写的信件或大字体。您也可以 要求与口译员对话。欲寻求帮助,请拨打您的 ID 卡上列出的免费电话号码。