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:

OptumRx
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.

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Services to help you communicate with us are provided at no cost to members, such as other languages or large print. Or, you can ask for an interpreter. To ask for help, please call Member Services at 1-800-348-4058, TTY 711, 8 a.m.–5 p.m., Monday–Friday.

Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI and VII) and the Americans with Disabilities Act of 1990 (ADA) Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, UnitedHealthcare Community Plan prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion, sex, national origin, age, and disability. UnitedHealthcare Community Plan must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. Auxiliary aids and services are available upon request to individuals with disabilities. For example, this means that if necessary, UnitedHealthcare Community Plan must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that UnitedHealthcare Community Plan will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy please contact: UnitedHealthcare Community Plan Member Services at 1-800-348-4058.