OPTUMRx®

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.

UnitedHealthcare Community Plan complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat people differently because of:

- Race
- National Origin
- Disability
- Color
- Age
- Sex/gender (expression or identity)

UnitedHealthcare Community Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

UnitedHealthcare Community Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact us toll-free at **1-888-980-8728**, TTY **711**.

If you believe that UnitedHealthcare Community Plan has failed to provide these services or has discriminated in any way, you can file a grievance with:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

Email: **UHC_Civil_Rights@uhc.com**

You can also file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

By mail: U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

By phone: **1-800-368-1019** (TDD: **1-800-537-7697**)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

(English) Do you need help in another language? We will get you a free interpreter. Call **1-888-980-8728** to tell us which language you speak. (TTY: **711**).
(Cantonese) 您需要其他语言吗？如果需要，请致电 **1-888-980-8728**，我们会提供免费翻译服务 (TTY: **711**).
(French) Avez-vous besoin d'aide dans une autre langue? Nous pouvons vous fournir gratuitement des services d'interprète. Appelez le **1-888-980-8728** pour nous indiquer quelle langue vous parlez. (TTY : **711**).
(German) Brauchen Sie Hilfe in einer anderen Sprache? Wir koennen Ihnen gern einen kostenlosen Dolmetscher besorgen. Bitte rufen Sie uns an unter **1-888-980-8728** und sagen Sie uns Bescheid, welche Sprache Sie sprechen. (TTY: **711**).
(Hawaiian) Makemake ʻoe i kōkua i pili kekahi ʻōlelo o nā ʻāina ʻē? E kiʻi nō mākou i mea unuhi manuahi nou. E kelepona i ka helu **1-888-980-8728** no ka haʻi ʻana mai iā mākou i ka ʻōlelo āu e ʻōlelo ai. (TTY: **711**).
(Ilocano) Masapulyo kadi ti tulong iti sabali a pagsasao? Ikkandakayo iti libre nga paraipatarus. Awaganyo ti **1-888-980-8728** tapno ibagayo kadakami no ania ti pagsasao nga ar-aramatenyo. (TTY: **711**).
(Japanese) 貴方は、他の言語に、助けを必要としていますか？私たちは、貴方のために、無料で通訳を用意できます。電話番号の、**1-888-980-8728** に、電話して、私たちに貴方の話されている言語を申し出てください。(TTY: **711**).
(Korean) 다른언어로 도움이 필요하십니까? 저희가 무료로 통역을 제공합니다. **1-888-980-8728** 로 전화해서 사용하는 언어를 알려주십시요 (TTY: **711**).
(Mandarin) 您需要其它語言嗎？如有需要，請致電 **1-888-980-8728**，我們會提供免費翻譯服務 (TTY: **711**)。
(Marshallese) Kwōj aikuj ke jipañ kōn juon bar kajin? Kōm naaj lewaj juon aṃ ri-ukok eo ejjeḷọk wōṇean. Kūrtok **1-888-980-8728** im kowaḷọk ñan kōm kōn kajin ta eo kwō meḷeḷe im kōnono kake. (TTY **711**).
(Samoan) E te manaʻo mia se fesosoani i se isi gagana? Matou te fesosoani e ave atu fua se faaliliu upu mo oe. Vili mai i le numera lea **1-888-980-8728** pea e manaʻo mia se fesosoani mo se faaliliu upu. (TTY: **711**).
(Spanish) ¿Necesita ayuda en otro idioma? Nosotros le ayudaremos a conseguir un intérprete gratuito. Llame al **1-888-980-8728** y díganos qué idioma habla. (TTY: **711**).
(Tagalog) Kailangan ba ninyo ng tulong sa ibang lengguwahe? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa **1-888-980-8728** para sabihin kung anong lengguwahe ang nais ninyong gamitin (TTY: **711**)
(Tongan) ʻOku ke fiemaʻu tokoni ʻiha lea makehe? Te mau malava ʻo ʻoatu ha fakatonulea taʻetotongi. Telefoni ki he **1-888-980-8728** ʻo fakaha mai pe koe ha ʻae lea fakafonua ʻoku ke ngaueʻaki. (TTY: **711**).
(Vietnamese) Bạn có cần giúp đỡ bằng ngôn ngữ khác không? Chúng tôi sẽ yêu cầu một người thông dịch viên miễn phí cho bạn. Gọi **1-888-980-8728** nói cho chúng tôi biết bạn dùng ngôn ngữ nào. (TTY: **711**).
(Visayan) Gakinahanglan ka ba ug tabang sa imong pinulongan? Amo kang mahatagan ug libre nga maghuhubad. Tawag sa **1-888-980-8728** aron magpahibalo kung unsa ang imong sinulti-han. (TTY: **711**).