# MEMBER REIMBURSEMENT DRUG CLAIM FORM

**Complete this form, attach prescription labels and mail to:**

*OptumRx*
*PO Box 29022*
*Hot Springs, AR 71903*

## Cardholder Information

| Cardholder's ID Number: | Group / Employer Name and Number: |
|---|---|
| Cardholder's Name: (Last, First, Middle) | Cardholder's Birthdate: (MM/DD/YYYY) |
| Cardholder's Address: (Street, City, State, Zip) | Cardholder's Telephone Number: ( ) |

## Patient Information

Prescription(s) were for:

| Patient Name: (First, Middle, Last) | Gender: ☐ Male ☐ Female | Employee ☐ Spouse ☐ Dependent ☐ | Patient Birthdate (MM/DD/YYYY) |
|---|---|---|---|

## Reason for Request

- ☐ Coordination of benefits with primary pharmacy or medical plan.
- ☐ Compound claim
- ☐ Out of area / urgent / emergency request
- ☐ Eligibility issue at the pharmacy
- ☐ Other, please describe:

## Pharmacy Information

| Pharmacy Name: | Pharmacy NABP Number: |
|---|---|
| Pharmacy Address: (Street, City, State, Zip) | |
| Pharmacy Telephone Number: ( ) | Pharmacist Signature: Date: |

## Prescription Information

*Please include the* **prescription labels** *with this form (receipts are not acceptable) or a pharmacy printout signed by the pharmacist. You can ask your* **pharmacist** *for assistance in completing the information below. Completing this entire form will result in timely processing of your claim. For questions concerning this claim please call the toll free number listed on your pharmacy ID card.*

| ❶Date Filled: | Rx Number: | Rx: (Check One) ☐New ☐Refill | Quantity: | Day's Supply: | National Drug Code: (11 digits) |
|---|---|---|---|---|---|
| Medication Name, Strength, Dosage Form: | | | Physician Name: | | NPI/DEA # / Rx Price Paid: |

| ❷Date Filled: | Rx Number: | Rx: (Check One) ☐New ☐Refill | Quantity: | Day's Supply: | National Drug Code: (11 digits) |
|---|---|---|---|---|---|
| Medication Name, Strength, Dosage Form: | | | Physician Name: | | NPI/DEA # / Rx Price Paid: |

| ❸Date Filled: | Rx Number: | Rx: (Check One) ☐New ☐Refill | Quantity: | Day's Supply: | National Drug Code: (11 digits) |
|---|---|---|---|---|---|
| Medication Name, Strength, Dosage Form: | | | Physician Name: | | NPI/DEA # / Rx Price Paid: |

**I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.**

Signature: Date:

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# NOTICE ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Members Health Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex in its health programs or activities.

We provide assistance free of charge to people with disabilities or whose primary language is not English. To request a document in another format such as large print or to get language assistance such as a qualified interpreter, please call the number located on the back of your prescription ID card, TTY 711. Representatives are available 24 hours a day, seven days a week.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to:

Civil Rights Coordinator
P.O. Box 1801
Columbia, TN 38402-1801
Phone: 1-844-223-3451, TTY 711
Fax: 1-931-388-8326
Email: civilrights@fbhealthplans.com

If you need help filing a complaint, please call the number located on the back of your prescription ID card, TTY 711. Representatives are available 24 hours a day, seven days a week. You can also file a complaint directly with the U.S. Dept. of Health and Human Services online, by phone, or by mail:

**Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)
**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building Washington, D.C. 20201

This information is available in other formats like large print. To ask for another format, please call the telephone number listed on your health plan ID card.

**Multi-language Interpreter Services**

**ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the telephone number listed on your health plan ID card. Representatives are available 24 hours a day seven days a week.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, TTY 711.

(Spanish)
Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711.

(Arabic)
ن تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم لـ ك الـ حق فـ ي الـ حـ صول عـ لى الـ مـ ساعدة والـ مـ عـ لومات بـ لـغـ تك دو
فـتـاهلا . 0الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على
117 ( YTT ( الـ ذ صي

(Chinese)
您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711

(Vietnamese)
Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711

(Korean)
귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다.
통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711

(Farsi)
توجه: اگر زبان شما **فارسی** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

(French)
Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d’affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.

(Laotian)
ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫ ຼືອແລະຂ ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບ ່ມີຄ່າໃຊ້ຈ່າ
ຍ. ເພື່ອຂ ຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສ
າລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711

(German)
Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711

(Gujarati)
તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાાં માહિતી મેળવિાનો અવિકાર છે. દુભાવષયા માટે વિનાંતી કરિા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નાંબર ઉપર કોલ કરો, 0 દબાવિો. TTY 711

(Japanese)
ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です

(Tagalog)
May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711

(Hindi)
आप के पास अपनी भाषा में सहायता एवं जानकारी ननःशुल्क प्राप्त करने का अधिकार है। दुभाषषए के लिए लिए अनुरोि करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोि-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711

(Russian)
Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711

(Turkish)
Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711

(Portuguese)
Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711

(Amharic)

ب رق م اتـ صل مـ ترجم، ط لب .تـ كـ لـ فة دون بـ ـلغ تهم والـ معـ لومات الـ مـ ساعدة عـ لى الـ حـ صول فـ ي الـ حق لـ ديـ ك فـ ي لألـ عـ ضاء الـ مجاند ي الـ هاتـ ف

0. TTY 711. وا ضغط الـهويـ ة بـ طاقة بـ ك الـ خا صة الـ صحـ ية الـ خطة