MEMBER REIMBURSEMENT DRUG CLAIM FORM

Complete this form, attach prescription labels and mail to:

OptumRx Claims Department
PO Box 650287
Dallas, TX 75265-0287

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:

DMRSTDCOMM_v02.091217

All Optum™ trademarks and logos are owned by Optum, Inc. All other brand or product names are trademarks or registered marks of their respective owners.
© 2017 Optum, Inc. All rights reserved.

NONDISCRIMINATION AND ACCESS TO COMMUNICATIONS NOTICE

Members Health Insurance Company (MHIC) complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, or sex. MHIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MHIC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, Braille).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters; and
  - Information in other languages.

If you need these services, contact Member Services at 1-866-643-6924, TTY 711, from 8AM to 8PM local time. Member Services is available Monday – Friday between April 1 – September 30 and 7 days a week between October 1 – March 30.

If you believe that MHIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

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

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint 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:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

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

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-855-540-4744 (TTY: 711).

Español
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-540-4744 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-540-4744 (TTY：711）

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-540-4744 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-540-4744 (TTY: 711)번으로 전화해 주십시오.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-540-4744 (телетайп: 711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-540-4744 (TTY: 711).

Arabic
اذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-540-4744 (رقم
ملحوظة:

فـتاه مصلا مكبلاو: 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-540-4744 (ATS : 711).

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با 1-855-540-4744 (TTY: 711) تماس بگیرید.

Laotian
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-540-4744 (TTY: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-540-4744 (TTY: 711).

Gujarati
□ચુના: જો તમે □જરાતી બોલતા હો, તો િન:□લ્ક ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો 1-855-540-4744 (TTY: 711).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-540-4744（TTY: 771）まで、お電話にてご連絡ください。

Hindi
ध्यान द□: य□द आप □हदी बोलते ह □तो आपके िलए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह।□ 1-855-540-4744 (TTY: 711) पर कॉल कर□।

Turkish
DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-540-4744 (TTY: 711) irtibat numaralarını arayın.

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-540-4744 (TTY: 711).

Amharic
□□□□□: □□□□□□ □□□ □□□□ □□□ □□□□□ □□□□ □□□□□□ □□□ □□□□□□ □□□□□□□□ □□ □□□□□ □□□ □□□□ 1-855-540-4744 (□□□□ □□□□□□: 711).