Optum Rx®

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.

1. Member information

Member ID (see ID card)	Health plan name			
Group/Employer name	Health plan state			
Last name	First name			MI
Mailing street address				Apt. #
City	State	ZIP	Date of Birth (mm/dd/yyyy)	

2. Physician and pharmacy information

Prescribing physician name	Pharmacy name
Prescribing physician phone number with area code	Pharmacy phone number with area code

3. Reason for request Select appropriate options for your request

Filled not using a prescription ID card ☐ YES ☐ NO
Covered under another health plan ☐ YES ☐ NO
- If yes, is this other plan Primary ☐ YES ☐ NO
- If primary, include the explanation of benefits (EOB), primary health plan name: _____
- See section C on back of form – Coordination of benefits

My pharmacy billed the wrong plan ☐ YES ☐ NO
A compound prescription ☐ YES ☐ NO
(Pharmacist must fill out Section B on back of form)
Retroactively enrolled with the plan ☐ YES ☐ NO
Filled while waiting for drug approval ☐ YES ☐ NO

Filled at a non-network pharmacy:
- Illness while traveling outside of service area ☐ YES ☐ NO
- Network pharmacy/mail order pharmacy within reasonable driving distance could not fill in a timely manner ☐ YES ☐ NO
- While a patient at a health care facility (emergency dept., provider clinic, outpatient surgery) ☐ YES ☐ NO
- Due to federal or state emergency/natural disaster ☐ YES ☐ NO

4. Acknowledgement

I certify that the patient for whom this claim is made is covered in this prescription drug program and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

X _____ _____

Member or authorized representative signature **Date**

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.

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: **Optum Rx Claims Department, PO Box 650287, Dallas, TX 75265-0287**.
4. Do not submit a reimbursement request if:
   - Your prescription claim has already been paid by the plan.
   - Your Part D plan copays or costs applied to your deductible.
   - You have been told the claim processed in the coverage gap.

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 your plan's limits, exclusions and provisions.

Section A – Pharmacy receipts for reimbursement

Use the following checklist to ensure your receipts have all information required for your reimbursement request:

☐ Date prescription filled
☐ National Drug Code (NDC) number
☐ Prescription number (Rx number)
☐ Name and address of pharmacy
☐ Name of drug and strength
☐ Quantity
☐ Prescribing physician name or ID number

Section B – Pharmacy information (for compound prescriptions ONLY)

(Pharmacist must complete and sign)

- 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.
- 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.

Rx#		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity*	Ingredient Cost†
Compounding Fee		
Total		

X _____
Signature of Pharmacist

Section C – Coordination of benefits

Sometimes you can have both Medicare and another insurance plan. They work together to pay claims for the same person. That process is called coordination of benefits. Insurance companies coordinate benefits to:
-Avoid duplicate payments by making sure the two plans don't pay more than the total amount of the claim.

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.

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Members Health Insurance Company complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, disability, age, sex, gender identity, sexual orientation, health status, marital status, arrest or conviction record, or military participation in the administration of the plan, including enrollment and benefit determinations.

Members Health Insurance Company:

- 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)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need any of these services, contact Member Services at 1-855-540-4744 (TTY 711). Our hours of operation are Oct. 1 - March 31, 8 a.m.– 8 p.m. 7 days/week local time, and April 1 - Sept. 30, 8 a.m. – 8 p.m., Monday - Friday local time.

If you believe Members Health Insurance Company has failed to provide these services or has discriminated in another way based on race, color, national origin, age, disability, or sex, health status, marital status, arrest or conviction record, or military participation, you can file a complaint or grievance with us. You can mail your grievance to:

Members Health Insurance Company
ATTN: Grievances
P.O. Box 240
Columbia, TN 38402

If you need assistance filing a complaint or grievance, please call Member Services at the phone number listed above.

You can also file a Civil Rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically or 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, D.C. 20201

1-800-368-1019
1-800-537-7697 (TDD)

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

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-999-0103. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-999-0103. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-833-999-0103。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-833-999-0103。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-999-0103. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-999-0103. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-999-0103 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-999-0103. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-999-0103 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-999-0103. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-833-999-0103.** سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-999-0103 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-999-0103. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-999-0103. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-999-0103. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-999-0103. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-833-999-0103 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。