UnitedHealthcare®
Community Plan

Prescription Drug Program
Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription label receipt(s).**
Cash register and credit card receipts alone are not acceptable as proof of purchase.
Reimbursement is not guaranteed.
Claims will be subject to limitations, exclusions and other provisions of the Plan Benefit.

Patient Information (one form per patient)

Health Plan (Insurance) Name *(please print)*		
Name *(Last Name, First Name, MI)*	Birth Date	I.D. Number
Mailing Address *(Number, Street, City, State & Zip Code)*		
Prescribing Physician's Name		Physician's Telephone Number

Reason For Request

(At least one must be checked)

☐ Out of Area emergency medication
☐ Compound medication
☐ Non-emergency medication/vacation request
☐ Member not found in pharmacy system
☐ No identification card or identification number available
☐ Other: _____
☐ Coordination of Benefits (From Primary Insurance – complete section below)

Coordination of Benefits

(If your primary insurance has already paid for the attached prescription, please complete this section.)

Primary Health Plan/Insurance Company Name _____
Primary Member/Subscriber's Name *(Last Name, First Name, MI)* _____
Primary Member/Subscriber's ID

I certify that the patient for whom this claim is made is a covered person 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 workers 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's/Subscriber's Signature Date

Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.

- Pharmacy Name
- Drug name, strength and quantity
- Prescribing physician's name
- Prescription number and date filled
- Member paid expense

The claim(s) will be returned if the member/subscriber's signature is not present.

Please mail label receipt(s) and this completed form to:

UnitedHealthcare Community Plan
Attention: Pharmacy
1 E Washington, Suite 900
Phoenix, AZ 85004

Reimbursement and correspondence will be issued to the primary member/subscriber.

WE SPEAK YOUR LANGUAGE

This document contains important information. Call **1-888-980-8728** (local customer service) to get the document in another language or have it orally translated for you.
Naglaon daytoy a dokumento iti napateg nga impormasion. Umawag iti **1-888-980-8728**
tapno maalam ti dokumento iti sabali a lengguahe wenno maibasa kenka iti maawatam a
lengguahe.
Taøi lieäu naøy chöùa thoâng tin quan troïng. Goïi **1-888-980-8728** (dòch vuï khaùch haøng
ñòa phöông) ñeå ñöôïc taøi lieäu baèng ngoân ngöõ khaùc hoaëc taøi lieäu naøy ñöôïc thoâng dòch
cho quyù vò.

本文件包含重要資訊。請撥打 **1-888-980-8728** 以獲得本文件的其他語言版本，

或讓人為您口譯該文件。

이 문서에는 중요한 정보가 수록되어 있습니다. 다른 언어로 번역된 문서를

받아보시거나

구두번역을 원하시면 **1-888-980-8728** 번으로 전화주십시오.