Pharmacy Direct Member Reimbursement Form - Medicaid

See the back for instructions. Complete all information. An incomplete form may delay the review of your request.

Member/Subscriber Information *See your PLAN ID card*

Member ID ☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last)

Street Address (Current)

City State Zip

Reason for Request: ____________________

Member Date of Birth (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Sex
☐ Female
☐ Male

Member Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

Pharmacy Information

Name of Pharmacy

Street Address

City State Zip

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐Yes ☐No

I hereby certify that the charge(s) shown for the medications prescribed is/are correct and agree to provide Medco Health or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that the reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Pharmacist or Representative **Pharmacy NPI Required**

Claim Receipts

Tape original claim receipts or itemized bills on the back. **Do not staple! Keep a copy of the form and your receipts for your records.**

Check the box if any of the receipts are for a medication that:

☐ **Is a compound prescription.** If so, make sure your pharmacist lists ALL the ingredients and quantities on the receipt.

Coordination of Benefits

Is this a coordination of benefits claim?
☐ Yes ☐ No

If "Yes" is this plan ☐ Primary, or
☐ Secondary

If "Secondary," check the primary payment method below. See the back for additional information.

☐ Major Medical (attach an Explanation of Benefit from the Primary Insurer)
☐ Card Program
☐ HMO
☐ Home Delivery / Mail Service

Please tape original receipts on the back.

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Member or Parent/Legal Guardian Date

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Original Claim Receipts

If you have more than two claim receipts or itemized bills to file with this request for reimbursement, tape the additional receipts anywhere on this page. **Do not staple!**

Tape receipt for prescription 1 here.

Tape receipt for prescription 2 here.

Prescription receipts must contain the following information:

- Date prescription was filled
- Name and address of the pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Instructions - Read carefully before completing this form

1. **Be sure your original receipts are complete.** In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not listed on your claim or bill.
2. The plan member should read the acknowledgement carefully, then sign and date this form.
3. **Keep a copy of the completed form and receipts for your records.**
4. Return the completed form and receipt(s) to:
   UnitedHealthcare Community Plan
   Pharmacy Management/COB
   Mail Stop: AZ009-900E
   1 E Washington Suite 900
   Phoenix, AZ 85004

When To Use This Form

- Use this form to submit claims under Coordination of Benefit Rules
- You must complete a separate claim form for each pharmacy used and for each patient.
- You must submit claims within one year of date of purchase or as required by your plan.

Coordination of Benefits

Major Medical Plans

You must first submit the claim to the primary insurance carrier. Once the Explanation of Benefits (EOB) is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided above, and attach the Explanation of Benefits from the primary insurance carrier.

Prescription Drug Card Programs or HMO Plans

If the primary plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no Explanation of Benefits is needed. Just complete this form, and attach the prescription receipt(s) that show the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the Explanation of Benefits.

Home Delivery/Mail Service

If the primary plan is home delivery/mail service, complete this form, and attach either the prescription receipts that show the co-payment or coinsurance paid to the home delivery/mail service pharmacy, or the statement of benefits you receive from the hoe delivery/mail service pharmacy.

For your protection, State law requires the following statement to appear on this form. Any person who knowingly presents false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.