PRESCRIPTION DRUG PROGRAM MEDICAID DIRECT MEMBER REIMBURSEMENT FORM

Use this form to get refunded if you paid retail cost for your covered prescription drug(s).

You can submit this form for any of these reasons:

- You're a new member and don't have your prescription ID card.
- Your pharmacy couldn't find your information in the pharmacy system.
- You were discharged from an inpatient facility after service hours.
- Your primary insurance has already paid for the attached prescription (Coordination of Benefits).
- You had an emergency outside of where you live and didn't have your prescription ID card (Provide proof of Urgent Care or Emergency Room Explanation of Benefits).

Read carefully before mailing your completed form.

- You must include the original prescription label receipt(s) and credit card or cash register receipts as proof of purchase.
- Submitting this form doesn't guarantee that you will get paid back.
- Claims will be subject to limitations, exclusions and other provisions of the Plan Benefit.
- Any refund or mailings will be sent to the primary plan member.
- The claim(s) will be returned if the form is not completed and signed by the plan member.

Your receipt(s) must have the following information:

- Pharmacy name
- Drug name, strength and quantity
- Prescribing doctor's name
- Prescription number and date filled
- The amount the member paid for the prescription(s)

If we can't read your receipts, your payment could be delayed, or you may not get paid back.

Mail the completed form and receipt(s) to:

OptumRx
P.O. Box 29044
Hot Springs, AR 71903

Questions?
Call the toll-free Member Services number on your member ID card.

Member information (Please print)

Health plan (insurance) name _____ Member ID _____ Date of birth _____

Last name, First name, Mi _____

Mailing address _____

Prescribing doctor's name _____ Prescribing doctor's phone number _____

Reason for request (At least one reason must be selected)

- ○ I'm a new member and didn't have my prescription ID card.
- ○ My pharmacy couldn't find my information in the pharmacy system.
- ○ I was discharged from an inpatient facility after service hours.
- ○ I had an emergency outside of where I live and didn't have my prescription ID card (Provide proof of Urgent Care or Emergency Room Explanation of Benefits).
- ○ My primary insurance has already paid for the attached prescription (See Coordination of Benefits section below).

Coordination of Benefits

Only fill out this section if your primary insurance has already paid for the attached prescription.

Primary health plan/Insurance company _____

Primary member name
(Last name, First name, Mi) _____

Primary member ID _____ Date _____

By signing this form I'm confirming that:

- The member for whom this claim is made is covered by this prescription drug program.
- This prescription is only for the named member.
- The claims I submitted for payment aren't eligible for payment under a no-fault automobile or workers' compensation insurance program.
- I authorize the release of all information for this claim to the plan administrator, underwriter, sponsored policy holder and/or employer.

Signature _____ Date _____

Please keep a copy of this form and receipts for your records.

UnitedHealthcare®
Community Plan

Nondiscrimination Statement

It is the policy of UnitedHealthcare Community Plan not to discriminate on the basis of race, color, national origin, sex, age or disability. UnitedHealthcare Community Plan has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Civil Rights Coordinator who has been designated to coordinate the efforts of UnitedHealthcare Community Plan to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for UnitedHealthcare Community Plan to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

You can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of UnitedHealthcare Community Plan relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** 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

1-800-868-1019, 1-800-537-7697 (TDD)

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**. Such complaints must be filed within 180 days of the date of the alleged discrimination.

UnitedHealthcare Community Plan will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

UnitedHealthcare®
Community Plan

Declaración Antidiscriminatoria

La política de UnitedHealthcare Community Plan es la de no discriminar en base a la raza, color, nacionalidad, sexo, edad o discapacidad. UnitedHealthcare Community Plan ha adoptado un procedimiento interno en casos de agravios para proveer una pronta y justa resolución a reclamaciones en las cuáles se alegue cualquier acción prohibida por la Sección 1557 del Acta de Cuidados Asequibles (Affordable Care Act - 42 U.S.C. 18116) y la implementación de sus regulaciones en 45 CFR parte 92, emitidas por el Departamento de Salud y Recursos Humanos de los Estados Unidos (U.S. Department of Health and Human Services). La Sección 1557 prohíbe la discriminación en bases de la raza, el color, la nacionalidad, el sexo, la edad o la discapacitación en ciertos programas de salud y de actividades. La Sección 1557 y sus regulaciones implementadas pueden ser examinadas en la oficina del Coordinador de los Derechos Civiles, quien es una persona que ha sido designada para coordinar los esfuerzos de UnitedHealthcare Community Plan para cumplir con los requisitos de la Sección 1557.

Cualquier persona que crea que alguien ha sido discriminado en base a su raza, color, nacionalidad, sexo, edad o discapacidad puede presentar una reclamación siguiendo este procedimiento. Es contra la ley que UnitedHealthcare Community Plan tome represalias en contra de cualquier persona que se oponga a la discriminación, presente una reclamación o participe en una investigación acerca de una acción discriminatoria.

Usted puede enviar una queja a:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

Procedimiento:

- Las reclamaciones deben presentarse ante el Coordinador de la Sección 1557 dentro de los primeros 60 días, a partir de la fecha en que la persona que presenta la reclamación tomó consciencia de ser objeto de una posible acción discriminatoria.
- Una reclamación debe presentarse por escrito y contener el nombre y la dirección de la persona que la presenta. La reclamación debe declarar cual es el problema o la posible acción discriminatoria y cuál es la solución o asistencia que se desea obtener.
- El Coordinador de la Sección 1557 (o la persona que se designe) podrá conducir una investigación acerca de esta reclamación. Esta investigación puede ser informal, pero será exhaustiva, ofreciendo a todas las personas interesadas una oportunidad para presentar evidencias relevantes a la reclamación. El Coordinador de la Sección 1557 conservará en su poder todos los expedientes y records de UnitedHealthcare Community Plan relativos a tales reclamaciones. En la medida posible y de acuerdo a las leyes vigentes aplicables,

el Coordinador de la Sección 1557 tomará todas las acciones necesarias para preservar la confidencialidad de los expedientes y records relativos a las reclamaciones y compartirá la información solamente con aquellas personas que tengan la necesidad de conocer esa información.

- El Coordinador de la Sección 1557 emitirá una decisión acerca de la reclamación, basándose en la preponderancia de la evidencia, no más tarde de 30 días a partir de la fecha en que se presentó esta reclamación y se incluirá una notificación para el demandante acerca de su derecho para proseguir con esta reclamación por medio de otras resoluciones legales o administrativas.

La disponibilidad y el uso de este procedimiento de reclamaciones no le impide a la persona que la presenta, proseguir con otras reclamaciones legales o administrativas, incluyendo la presentación de una reclamación por discriminación basada en la raza, color, nacionalidad, sexo, edad o discapacidad en la corte o ante el Departamento de Salud y Recursos Humanos de los Estados Unidos, Oficina de los Derechos Civiles (U.S. Department of Health and Human Services, Office for Civil Rights). Una persona puede presentar una reclamación por discriminación electrónicamente a través del portal de la Oficina de Reclamaciones para los Derechos Civiles (Office for Civil Rights Complaint Portal), disponible en: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** o hacerlo por correo a la dirección:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-868-1019, 1-800-537-7697 (TDD)

Las formas para las reclamaciones se encuentran disponibles en: **http://www.hhs.gov/ocr/office/file/index.html**. Estas reclamaciones deben presentarse dentro de los primeros 180 días a partir de la fecha en que esta posible acción discriminatoria tuvo lugar.

UnitedHealthcare Community Plan llevará a cabo todos los arreglos necesarios para asegurar que a las personas con discapacidades o aquellas personas con un limitado dominio del idioma inglés se les provea con apoyos auxiliares y servicios o asistencia en el lenguaje, respectivamente, si existe la necesidad de que estas personas tengan que participar en este procedimiento de reclamación. Tales arreglos pueden incluir, pero no estar limitados a, proveer intérpretes calificados, proveer casetes conteniendo el material para aquellos individuos con problemas de visión o asegurando localidades existentes para los procedimientos que sean libres de barreras que impidan el acceso a los procedimientos. El Coordinador de la Sección 1557 será la parte responsable para esos arreglos.

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Language Accessibility Statement

Interpreter Services Are Available for Free

Help is available in your language: ***1-800-318-8821, TTY 711****.*
These services are available for free.

Español/Spanish
Hay ayuda disponible en su idioma: **1-800-318-8821, TTY 711**. Estos servicios están disponibles de forma gratuita.

አማርኛ/Amharic
እገዛ በቋንቋዎ ማግኘት ይችላሉ፦ **1-800-318-8821** መስማት ለተሳናቸው/ **TTY፦ 711**።
እነዚህን አገልግሎቶች ያለ ምንም ክፍያ ማግኘት ይቻላል።

العربية/Arabic
المساعدة متوفرة بلغتك: اتصل على الرقم **1-800-318-8821**، الهاتف النصي: **711**. هذه الخدمات متوفرة مجانًا.

中文/Chinese
用您的语言为您提供帮助：**1-800-318-8821, TTY 711**。这些服务都是免费的。

فارسی /Farsi
خط تلفن کمک به زبانی که شما صحبت می کنید : **1-800-318-8821**، خط تماس برای افراد ناشنوا **711**.
این خدمات به صورت رایگان در دسترس هستند.

Français/French
Vous pouvez disposer d'une assistance dans votre langue : **1-800-318-8821, TTY 711**. Ces services sont disponibles gratuitement.

ગુજરાતી/Gujarati
તમારી ભાષામાં મદદ ઉપલબ્ધ છે: **1-800-318-8821** ટીટીવાય: **711**. આ સેવાઓ મફત ઉપલબ્ધ છે.

Kreyòl Ayisyen/Haitian Creole
Gen èd ki disponib nan lang ou: **1-800-318-8821, TTY 711**. Sèvis sa yo disponib gratis.

Igbo
Ọrụ Ndị Ọkọwa Okwu Dị N'efu Enyemaka dị n'asụsụ gị: **1-800-318-8821**, **TTY 711.** Ọrụ ndị a dị n'efu.

한국어/Korean
사용하시는 언어로 지원해드립니다: **1-800-318-8821**, **TTY 711**. 이 서비스는 무료로 제공됩니다.

Português/Portuguese
Está disponível ajuda no seu idioma: **1-800-318-8821**, **TTY 711**. Estes serviços são disponibilizados gratuitamente.

Русский/Russian
Помощь доступна на вашем языке: **1-800-318-8821**, **TTY 711.** Эти услуги предоставляются бесплатно.

Tagalog
Makakakuha kayo ng tulong sa inyong wika: **1-800-318-8821**, **TTY 711**. Ang mga serbisyong ito ay makukuha ng libre.

اردو/Urdu
آپ کی زبان میں مدد دستیاب ہے: **1-800-318-8821**، ٹی ٹی وائی: **711**۔ یہ خدمات مفت میں دستیاب ہیں۔

Tiếng Việt/Vietnamese
Có hỗ trợ ngôn ngữ của quý vị: **1-800-318-8821**, **TTY 711.** Các dịch vụ này được cung cấp miễn phí.

Yorùbá/Yoruba
Ìrànlọ́wọ́ wà ní àrọ́wọ́tó ní èdè rẹ: **1-800-318-8821**, **TTY 711.** Àwọn iṣẹ́ yìí wà ní àrọ́wọ́tó lọ́fẹ̀ẹ́.