



## 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 member 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 member 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 member 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 member 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 does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, 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**

You must submit the complaint orally or in writing within 30 days of when you found out about it. If your complaint cannot be resolved in 1 day it will be treated as a grievance. We will send you an acknowledgement of the grievance within 5 days of receipt of the grievance. A decision will be sent to you within 30 days.

If you need help with your complaint, please call the toll-free member phone number at **1-877-743-8731, TTY 711**, Monday through Friday, 8:00 a.m. to 5:00 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:**

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at

<http://www.hhs.gov/ocr/office/file/index.html>

**Phone:**

Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

**Mail:**

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

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number at **1-877-743-8731, TTY 711**, Monday through Friday, 8:00 a.m. to 5:00 p.m.

## English

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-877-743-8731, TTY 711**.

## Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-743-8731, TTY 711**.

## Vietnamese

LƯU Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số **1-877-743-8731, TTY 711**.

## Traditional Chinese

注意：如果您說中文，您可獲得免費語言協助服務。請致電 **1-877-743-8731**，或聽障專線 **TTY 711**。

## French

ATTENTION : Si vous parlez français, vous pouvez obtenir une assistance linguistique gratuite. Appelez le **1-877-743-8731, TTY 711**.

## Arabic

تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم **1-877-743-8731**، الهاتف النصي **.711**

## Choctaw

Pisa: Chahta anumpa ish anumpuli hokma, anumpa tohsholi yvt peh pilla ho chi apela hinla. I paya **1-877-743-8731, TTY 711**.

## Tagalog

ATENSYON: Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa **1-877-743-8731, TTY 711**.

## German

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachendienste zur Verfügung. Wählen Sie: **1-877-743-8731, TTY 711**.

## Korean

참고: 한국어를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-877-743-8731, TTY 711** 로 전화하십시오.

## Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમારા માટે વિના મૂલ્યે ભાષાકીય સહાયતા સેવાઓ ઉપલબ્ધ છે. કોલ કરો **1-877-743-8731, TTY 711**.

## Japanese

ご注意:日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。電話番号**1-877-743-8731**、または**TTY 711**。

## Russian

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел **1-877-743-8731, TTY 711**.

## Panjabi

ਸਾਵਧਾਨ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ, ਮੁਫਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਹੈਲਪ ਪਲਾਨ ਟੀਮ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। **1-877-743-8731, TTY 711** ਤੇ ਕਾਲ ਕਰੋ।

**Italian**

ATTENZIONE: se parla italiano, Le vengono messi gratuitamente a disposizione servizi di assistenza linguistica. Chiami il numero **1-877-743-8731, TTY 711**.

**Hindi**

धुनन दे: डदल आड हलनुदी डलषल डुलते हलँ तु डलषल सलहलड तल सेवलडं आडके ललड नलःशुलुक उडललडुध हलँ। कलल करलँ **1-877-743-8731, TTY 711**.