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 you 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

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 **1-800-992-9940**, **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 **1-800-992-9940**, **TTY 711**, Monday through Friday, 8:00 a.m. to 5:00 p.m.

UnitedHealthcare®
Community Plan

UnitedHealthcare Community Plan no da un tratamiento diferente a sus miembros en base a su sexo, edad, raza, color, discapacidad o origen nacional.

Si usted piensa que ha sido tratado injustamente por razones como su sexo, edad, raza, color, discapacidad o origen nacional, 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

Usted tiene que presentar la queja oralmente o por escrito dentro de los primeros 30 días a partir de la fecha cuando se enteró de ella. Si su queja no puede resolverse un un día, se le considerará como reclamación. Nosotros le enviaremos una notificación de recibido de su reclamación dentro de los primeros 5 días después de haberla recibido. Se le enviará la decisión en un plazo de 30 días.

Si usted necesita ayuda con su queja, por favor llame al número de teléfono gratuito para miembros **1-800-992-9940**, **TTY 711**, de lunes a viernes, de 8:00 a.m. a 5:00 p.m.

Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Internet:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Formas para las quejas se encuentran disponibles en:
http://www.hhs.gov/ocr/office/file/index.html

Teléfono:
Llamada gratuita, **1-800-368-1019**, **1-800-537-7697** (TDD)

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

Ofrecemos servicios gratuitos para ayudarle a comunicarse con nosotros. Tales como, cartas en otros idiomas o en letra grande. O bien, puede solicitar un intérprete. Para pedir ayuda, por favor llame al número de teléfono gratuito para miembros **1-800-992-9940**, **TTY 711**, de lunes a viernes, de 8:00 a.m. a 5:00 p.m.

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-992-9940, TTY 711.**

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-992-9940, 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 **1-800-992-9940, 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 **1-800-992-9940**，或聽障專線 **TTY 711**。

French
ATTENTION : Si vous parlez français, vous pouvez obtenir une assistance linguistique gratuite. Appelez le **1-800-992-9940, TTY 711**.

Arabic
تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم **1-800-992-9940**، الهاتف النصي **711**.

Choctaw
Pisa: Chahta anumpa ish anumpuli hokma, anumpa tohsholi yvt peh pilla ho chi apela hinla. I paya **1-800-992-9940, TTY 711**.

Tagalog
ATENSYON: Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa **1-800-992-9940, TTY 711**.

German
HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachendienste zur Verfügung. Wählen Sie: **1-800-992-9940, TTY 711**.

Korean
참고: 한국어를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-800-992-9940**, **TTY 711** 로 전화하십시오.

Gujarati
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમારા માટે વિના મૂલ્યે ભાષાકીય સહાયતા સેવાઓ ઉપલબ્ધ છે. કોલ કરો **1-800-992-9940, 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 **1-800-992-9940**、または **TTY 711**。

Russian
ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел **1-800-992-9940, TTY 711**.

Panjabi
ਸਾਵਧਾਨ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ, ਮੁਫ਼ਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਹੈਲਥ ਪਲਾਨ ਟੀਮ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। **1-800-992-9940, TTY 711** ਤੇ ਕਾਲ ਕਰੋ।

Italian
ATTENZIONE: se parla italiano, Le vengono messi gratuitamente a disposizione servizi di assistenza linguistica. Chiami il numero **1-800-992-9940, TTY 711**.

Hindi
ध्यान दें: यदि आप हिन्दी भाषा बोलते हैं तो भाषा सहाय ता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल करें **1-800-992-9940, TTY 711**.