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.

OPTUMRx

UnitedHealthcare Community Plan of Ohio, Inc. does not discriminate because of sex, age, race, color, disability or national origin.

If you believe that we have failed to provide these services or discriminated in another way on the basis of sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

- **Online:** UHC_Civil_Rights@uhc.com
- **Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call 1-800-895-2017 (TTY 711) from 7 a.m. to 7 p.m. Monday through Friday (voicemail available 24 hours a day/7 days a week).

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, 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 1-800-895-2017 (TTY 711) from 7 a.m. to 7 p.m. Monday through Friday (voicemail available 24 hours a day/7 days a week).

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-800-895-2017, TTY 711.

ATENCIÓN: si habla **español (Spanish)**, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-895-2017, TTY 711.

注意：如果您說**中文 (Chinese)**，您可獲得免費語言協助服務。請致電 1-800-895-2017，或聽障專線 (TTY) 711。

LƯU Ý: Nếu quý vị nói Tiếng **Việt (Vietnamese)**, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số 1-800-895-2017, TTY 711.

참고: **한국어(Korean)**를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. 1-800-895-2017, TTY 711 로 전화하십시오.

ATENSYON: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa 1-800-895-2017, TTY 711.

ВНИМАНИЕ: Если вы говорите по-**русском (Russian)**, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел 1-800-895-2017, TTY 711.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-800-895-2017، الهاتف النصي 711.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-800-895-2017, TTY 711.

ATTENTION : Si vous parlez **français (French)**, vous pouvez obtenir une assistance linguistique gratuite. Appelez le 1-800-895-2017, TTY 711.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-800-895-2017, TTY 711.

ATENÇÃO: Se fala **português (Portuguese)**, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-895-2017, TTY 711.

ATTENZIONE: se parla **italiano (Italian)**, Le vengono messi gratuitamente a disposizione servizi di assistenza linguistica. Chiami il numero 1-800-895-2017, TTY 711.

HINWEIS: Wenn Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachendienste zur Verfügung. Wählen Sie: 1-800-895-2017, TTY 711.

ご注意：**日本語 (Japanese)** 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1-800-895-2017、またはTTY 711 （聴覚障害者・難聴者の方用）までご連絡ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
1-800-895-2017 تماس بگیرید، TTY 711.

ध्यान दें: यदि आप **हिन्दी (Hindi)** भाषा बोलते हैं तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल करें 1-800-895-2017, TTY 711.

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-800-895-2017, TTY 711.

ចំណាប់អារម្មណ៍៖ បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-800-895-2017។ TTY 711។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kaniam. Maidawat nga awagan iti 1-800-895-2017, TTY 711.

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné (Navajo)** Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-895-2017, TTY 711.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-800-895-2017, TTY 711.

ध्यान दिनुहोस्: यदि तपाईं **नेपाली (Nepali)** भाषा बोल्नुहुन्छ भने तपाईंको लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। कृपया 1-800-895-2017, TTY 711, मा फोन गर्नुहोस्।

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

OPTUMRx®

XIYYEEFFANNOO: Afaan **Kushaitii (Cushite)** dubbattu yoo ta'e, tajaajilli gargaarsa afaanii, kanfaltii malee isiniif ni argama. Maaloo lak. 1-800-895-2017 n TTY 711 n bilbila'a.

LET OP: Als u **Nederlands (Dutch)** spreekt, kunt u gratis gebruikmaken van taalhulpdiensten. Bel 1-800-895-2017, TTY 711.

WICHTIG: Wann du **Deitsch schwetzscht (Pennsylvania Dutch)** un Hilf witt mit Englisch, kenne mer dich helfe, unni as es dich ennich ebbes koschte zellt. Ruf 1-800-895-2017, TTY 711 aa.

ATENȚIE: Dacă vorbiți limba **română (Romanian),** aveți la dispoziție servicii de asistență lingvistică gratuite. Sunați la 1-800-895-2017, TTY 711.

УВАГА: Якщо ви не говорите **українською (Ukrainian)** мовою, ви можете скористатися безкоштовними послугами перекладача. Телефонуйте за номером 1-800-895-2017, TTY 711.