Prescription Drug Program
Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription label receipt(s). Physician generated receipt(s) are acceptable for vaccine and vaccine administration requests only.**

Cash register and credit card receipts alone are not acceptable as proof of purchase.

Reimbursement is not guaranteed.

Claims will be reviewed and subject to limitations, exclusions and other provisions of the Plan Benefit.

Patient Information (one form per patient)

Health Plan/Insurance Name & State *(please print)*	Group/Employer Name	HIC Number
Name *(Last Name, First Name, MI)*	Birth Date	I.D. Number
Mailing Address *(Number, Street, City, State & Zip Code)*		Social Security Number
Member Phone Name	Prescribing Physician's Name	Physician's Telephone Number

Reason For Request

(At least one must be checked)

- ☐ Out of Area urgent/emergent medication
- ☐ Non urgent medication/vacation request
- ☐ No identification card or identification number available
- ☐ Eligible member/group invalid
- ☐ Referral non-contracted physician/self referral
- ☐ Compound medication
- ☐ Non-contracted pharmacy
- ☐ Other:_____
- ☐ Coordination of Benefits (From Primary insurance - complete section below)

Coordination of Benefits

(If your primary insurance has already paid for the attached prescription, please complete this section.)

Primary Health Plan/ Insurance Company Name _____

Primary Member/Subscriber's Name *(Last Name, First Name, MI)*_____

Primary Member/Subscriber's ID_____

Vaccine

Itemized *Physician generated recieipts are acceptable for vaccines and vaccine administration only.*

Proof of payment must be included.

- ☐ Filled at pharmacy, and administered at physician's office
- ☐ Filled and administered at pharmacy
- ☐ Filled and administered at physician's office

Check below all that apply to the cost of the claim

- ☐ Vaccine and Administration Cost
- ☐ Vaccine Cost

I certify that the patient for whom this claim is made is a covered person in this prescription drug plan and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

X_____ _____

Member's/Subscriber's Signature Date

Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.
Physician receipt must have those items listed with an asterisk or reimbursement could be delayed or denied.

- Pharmacy Name
- Drug name*, strength, and quantity*
- Prescribing physician's name*
- Prescription number
- Date filled*
- Member paid expense*

The claim(s) will be returned if the member/subscriber's signature is not present.

Please mail label receipt(s) and this completed form to:

UnitedHealthcare
ATTN: Pharmacy Department
4 Gateway Center, 4th floor
Newark, NJ 07102

Reimbursement and correspondence will be issued to the primary member/subscriber.