Optum Rx®

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 didn'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:

Optum Rx
P.O. Box 650334
Dallas, TX 75265-0334

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

TURQUOISECARE

UnitedHealthcare Community Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. In other words, UnitedHealthcare Community Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UnitedHealthcare Community Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact UnitedHealthcare Community Plan at the toll-free member phone number listed on your health plan member ID card, TTY 711.

If you feel that UnitedHealthcare Community Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or email:

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

UHC_Civil_Rights@uhc.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail at:

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

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

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

UnitedHealthcare Community Plan cumple con los requisitos fijados por las leyes Federales de los derechos civiles y no discrimina en base a raza, color, nacionalidad, edad, discapacidad o sexo. En otras palabras, UnitedHealthcare Community Plan no excluye a las personas ni las trata de manera diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

UnitedHealthcare Community Plan:

- Provee asistencia y servicios gratuitos de ayuda para las personas con discapacidades en su comunicación con nosotros, con:
  - Intérpretes calificados en el lenguaje de señas
  - Información por escrito en diferentes formatos (letras de mayor tamaño, audición, formatos electrónicos accesibles, otros formatos)
- Provee servicios gratuitos con diversos idiomas para personas para quienes el inglés no es su lengua materna, como:
  - Intérpretes calificados
  - Información impresa en diversos idiomas

Si usted necesita estos servicios, por favor llame gratuitamente al número para miembros anotado en su tarjeta de identificación como miembro del plan de salud, TTY 711.

Si usted piensa que UnitedHealthcare Community Plan no le ha brindado estos servicios o le ha tratado a usted de manera diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo, usted puede presentar una queja por correo o correo electrónico a:

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

UHC_Civil_Rights@uhc.com

Usted también puede presentar una queja acerca de sus derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos, Oficina de Derechos Civiles, electrónicamente a través del sitio para quejas de la Oficina de Derechos Civiles en **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** o por correo en:

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

Teléfono:
Gratuitamente al **1-800-368-1019**, **1-800-537-7697** (TDD)

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

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-877-236-0826, TTY 711.**

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-236-0826, TTY 711**.

Navajo
Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-877-236-0826, 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 **1-877-236-0826, TTY 711**.

German
HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachendienste zur Verfügung. Wählen Sie **1-877-236-0826, TTY-Gerät 711**.

Chinese
注意：如果您說中文，您可獲得免費語言協助服務。請致電 **1-877-236-0826**，或聽障專線 **(TTY) 711**。

Arabic
تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم **1-877-236-0826**، الهاتف النصي **711**.

Korean
참고: 한국어를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-877-236-0826, TTY 711**로 전화하십시오.

Tagalog
ATENSYON: Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa **1-877-236-0826, 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**1-877-236-0826**、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。

French
ATTENTION : Si vous parlez français, vous pouvez obtenir une assistance linguistique gratuite. Appelez le **1-877-236-0826, ATS 711**.

Italian
ATTENZIONE: se parla italiano, Le vengono messi gratuitamente a disposizione servizi di assistenza linguistica. Chiami il numero **1-877-236-0826, TTY 711**.

Russian
ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел. **1-877-236-0826, TTY 711**.

Hindi
ध्यान दें: यदि आप हिन्दी भाषा बोलते हैं तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल करें **1-877-236-0826, TTY 711**.

Farsi
توجه: اگربه زبان فارسی صحبت می کنید. خدمات ترجمه زبان به صورت رایگان به شما ارائه خواهد شد. لطفا باشماره تلفن **1-877-236-0826**، **TTY 711** تماس بگیرید.

Thai
ข้อควรพิจารณา: หากท่านพูดภาษาไทย จะมีบริการให้ความช่วยเหลือด้านภาษาฟรีโดยไม่มีค่าใช้จ่าย โปรดโทรไปที่หมายเลข **1-877-236-0826, TTY 711**