MEMBER REIMBURSEMENT DRUG CLAIM FORM

Complete this form, attach prescription labels and mail to:

OptumRx
PO Box 968022
Schaumburg, IL 60196-8022

Cardholder Information

Cardholder's ID Number:	Group / Employer / Name and Number:
Cardholder's Name: (Last, First, Middle)	Cardholder's Birthdate: (MM/ DD/ YYYY)
Cardholder's Address: (Street, City, State, Zip)	Cardholder's Telephone Number: ( )

Patient Information

Prescription(s) were for:

Patient Name: (First, Middle, Last)	Gender: ☐ Male ☐ Female	Employee ☐	Spouse ☐	Dependent ☐	Patient Birthdate (MM/DD/YYYY)

Reason for Request

- ☐ Coordination of benefits with primary pharmacy or medical plan.
- ☐ Compound claim
- ☐ Out of area / urgent / emergency request
- ☐ Eligibility issue at the pharmacy
- ☐ Other, please describe:

Pharmacy Information

Pharmacy Name:	Pharmacy NABP Number:
Pharmacy Address: (Street, City, State, Zip)	
Pharmacy Telephone Number: ( )	Pharmacist Signature: Date:

Prescription Information

Please include the prescription labels with this form (receipts are not acceptable) or a pharmacy printout signed by the pharmacist. You can ask your pharmacist for assistance in completing the information below. Completing this entire form will result in timely processing of your claim. For questions concerning this claim please call the toll free number listed on your pharmacy ID card.

❶ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)	
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #	Rx Price Paid:
❷ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)	
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #	Rx Price Paid:
❸ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)	
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #	Rx Price Paid:

I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Signature: Date:

All Optum™ trademarks and logos are owned by Optum, Inc. All other brands or product names are trademarks or registered marks of their respective owners.
© 2015 Optum, Inc. All rights reserved.

Número de identificación del titular de la tarjeta:	Nombre y número del grupo / empleador:
Nombre del titular de la tarjeta: (Apellido, primer nombre, segundo nombre)	Fecha de nacimiento del titular de la tarjeta: (MM/DD/AAAA)
Dirección del titular de la tarjeta: (Calle, ciudad, estado, código postal)	Número de teléfono del titular de la tarjeta: ( )

Recetas para:

Nombre del paciente: (Primer nombre, segundo nombre, apellido)	Sexo:	Empleado	Cónyuge	Persona a cargo	Fecha de nacimiento del paciente: (MM/DD/AAAA)
	☐ Hombre ☐ Mujer	☐	☐	☐	

Firma:

Fecha:

‘1G!Y$B-L2Z L6G6
‘.)Q!F\‘]I6-@(:6
]E%--5E%M%UUU5-5