PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. **Please print clearly. Additional information and instructions on back, please read carefully.**

1 Member information

RMHP Member ID *(see ID card)* | Group/Employer Name

Last name | First name | MI

Mailing street address | Apt. #

City | State | ZIP

Prescription is for O Self O Spouse O Dependent

Gender O M O F

Date of birth *(mm/dd/yyyy)* __ __ / __ __ / __ __ __ __

2 Physician and pharmacy information

Prescribing physician name | Dispensing pharmacy name

Prescribing physician phone number with area code | Dispensing pharmacy phone number with area code

3 Reason for request Select appropriate options for your request

Was this prescription given to you because of an urgent or emegency situation? O YES O NO

- O I did not use my Prescription Drug ID card
- O RMHP participating pharmacy for one of the following reasons:
  - O I traveled outside RMHP's service area and needed my medication but could not access a network pharmacy.
  - O I could not get my medication in a timely manner from either a network pharmacy located within a reasonable driving distance or a network mail service pharmacy.
  - O A non-network pharmacy located within a care institution dispensed my medication (for example emergency department, health clinic, outpatient surgery or other outpatient facility)
  - O I was evacuated or displaced from my residence due to a state or federally declared disaster or health emergency.
- O I filled a compound prescription *(your pharmacist must complete section B of this form)*
- O My primary coverage is with another insurance carrier *(coordination of benefits claim, see Section D for details).*
  - O I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare Primary Health Plan Name: ____________________________
  - O I am submitting a copay receipt
- O I was waiting for approval of my medication from RMHP
- O I was retroactively enrolled with the plan
- O My pharmacy billed the wrong plan
- O Vaccine and/or vaccine administration. *See Section C.*
- O Other *(please explain)*______________________________
  ____
  ____
  ____

4 Acknowledgement

I certify that the patient for whom this claim is made is covered in this prescription drug program 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 or Authorized Representative Signature **Date:**

NOTE: If form is completed and signed by an Authorized Representative rather than the member, an Authorization of Representative (AOR) must accompany the request or Power of Attorney (POA) must be on file with the plan.

Instructions for Mailing Form

1. Include the original **pharmacy receipt** for each medication (not the **register receipt**). Pharmacy receipt(s) must contain the information in Section A (below) If you do not have pharmacy receipt(s), ask your pharmacy to provide them to you.
2. Read the Acknowledgement (Section 4) on the first page of this form very carefully. Then sign and date.
3. **Commercial Members** - send completed form with pharmacy receipt(s) to: **OptumRx Claims Department, PO Box 29077, Hot Springs, AR, 71903.**
4. **Medicaid Prime Members and Medicare Part B Members** - send completed form with pharmacy receipt(s) to: **OptumRx Claims Department, PO Box 29044, Hot Springs, AR, 71903.**

NOTE: **Cash and credit card receipts are not proof of purchase.** Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions. We can only reimburse you for our price for the drug, which may be less than the retail price you paid.

Section A – Pharmacy receipt(s) for reimbursement

Use the following checklist to ensure your original pharmacy receipt(s) have all information required for your reimbursement request:

- ○ Date prescription filled
- ○ Name and address of pharmacy
- ○ Prescribing physician name or ID number
- ○ National Drug Code (NDC) number
- ○ Name of drug and strength
- ○ Amount paid by member
- ○ Prescription number (Rx number)
- ○ Quantity

Section B – Pharmacy information *(for compound prescriptions ONLY)*

Pharmacist must complete and sign

- List VALID 11 digit NDC number (highest to lowest cost) in the box below, Include EACH ingredient used in the compound
- For each NDC number, indicate the metric quantity expressed as the number of tablets, grams, or milliliters
- Indicate the TOTAL amount paid by the patient.
- Receipt(s) must be provided with this claim form.

* Individual quantities must equal the total quantity.

† Individual ingredient costs plus compounding fees must be equal to the total ingredient costs.

Rx#	**Days Supply:**	**Date Filled:**	
VALID 11 digit NDC#	**Drug/Ingredient**	**Quantity***	**Ingredient Cost†**
	Compounding Fee	X	
	Total		

X ____

Signature of Pharmacist

Section C – Vaccines

Clinic, pharmacy or dispensing facility must complete

Provider Name | Provider NPI Number

Brand name of vaccine | Date administered

Member price of vaccine | Member administration fee for vaccine

NDC Number for vaccine | Reason for vaccine: ○ Routine/Preventive ○ Treatment for injury or illness

Brand name of vaccine | Date administered

Member price of vaccine | Member administration fee for vaccine

NDC Number for vaccine | Reason for vaccine: ○ Routine/Preventive ○ Treatment for injury or illness

Section D – Coordination of Benefits

You must submit claims within 120 days of date of purchase or as required by your plan.

When submitting an Explanation of Benefits (EOB) from another health plan or Medicare: If you have not already done so, submit the claim to the primary plan or Medicare. Once you receive the EOB, complete this form, submit the pharmacy receipt(s), and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the primary plan or Medicare.

When submitting a copay receipt: If your primary plan requires you to pay a copayment or coinsurance to the pharmacy, then no EOB is needed. Just complete this form and submit the pharmacy receipt(s) showing the amount you paid at the pharmacy. This receipt(s) will serve as the EOB.

Section E – Timely Filing

You must submit your claim to us within 120 days of the date you received the prescription(s).

Section F – Customer Service Numbers

If you have any questions, be sure to ask the pharmacist. If you need help, or additional forms, please call Rocky Mountain Health Plans Customer Service.

Commercial (Para asistencia en español llame al) .... 970-243-7050 or 800-346-4643

Medicaid Prime (Para asistencia en español llame al) .... 970-244-7860 or 888-282-8801

Medicare Part B (Para asistencia en español llame al) .... 970-244-7912 or 888-282-1420

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

*__Arizona:__ For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.

*__California:__ For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通，我们提供一些免费服务，例如用其他语言书写的信件或大字体。您也可以要求与口译员对话。欲寻求帮助，请拨打您的 ID 卡上列出的免费电话号码。