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 are below, please read carefully.

MEMBER INFORMATION

RMHP Member ID | Group/Employer Name

Last Name | First Name | MI

Mailing Street Address | Apt. #

City | State | Zip | Prescription is for: ☐ Self ☐ Spouse ☐ Dependent | Gender ☐M ☐F

Date of Birth (mm/dd/yyyy) ☐☐ ☐☐ ☐☐☐☐

PHYSICIAN AND PHARMACY INFORMATION

Prescribing physician name | Dispensing pharmacy name

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

REASON FOR REQUEST (Select appropriate options for your request)

Was this prescription given to you because of an urgent or emergency situation? ☐ Yes ☐ No

☐ I did not use my Prescription Drug ID card

☐ Did not use an RMHP participating pharmacy for one of the following reasons:

- ☐ I traveled outside of RMHP's service area and needed my medication but could not access a network pharmacy.
- ☐ 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.
- ☐ A non-network pharmacy located within a care institution dispensed my medication (for example emergency department, health clinic, outpatient surgery or other outpatient facility)

☐ I filled a compound prescription **(Your pharmacist must complete Section B of this form)**

☐ My primary coverage is with another insurance carrier **(Coordination of Benefits claim, see Section D for details)**

- ☐ I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare
  Primary Health Plan Name: _____
- ☐ I am submitting a copay receipt

☐ I was waiting for approval of my medication from RMHP

☐ I was retroactively enrolled with the plan

☐ My pharmacy billed the wrong plan

☐ Vaccine and/or vaccine administration **(See Section C)**

☐ Other (please explain, may continue on back of form, if needed)

_____

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 the pharmacy receipt(s), ask your pharmacy to provide them to you.
2. Read the Acknowledgement on the first page of this form very carefully. Then sign and date.

3. **Commercial, Exchange and Medicaid Members** – Send completed form with pharmacy receipt(s) to:
   OptumRx Claims Department
   PO Box 650540
   Dallas, TX 75265-0540
4. **Medicare Members** – send completed form with pharmacy receipt(s) to:
   OptumRx Claims Department
   PO Box 650287
   Dallas, TX 75265-0287

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 of 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 the 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 cost

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

NOTE: if available, have your pharmacy rerun the claims through the appropriate primary and secondary insurance according to your health coverage ID cards. You may be due a refund from your pharmacy.

You may submit 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:

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.*

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±划*rI活V3中歧视AEEfSA。

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。