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 don't have your 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.
- Your claim may be changed due to your plan guidelines.
- 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:

OptumRx
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 name	Member ID	Date of Birth
Last name	First name	Middle Initial
Mailing address	City, State	ZIP code
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.

Today's date	Primary member ID #	
Primary health plan		
Primary member: Last name	First name	Middle Initial

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.

United Healthcare Community Plan

Contract services are funded under contract with the State of Indiana. UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

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

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 calendar days of when you found out about it. A decision will be sent to you within 30 calendar days. If you disagree with the decision, you have 15 calendar days to ask us to look at it again.

If you need help with your complaint, please call Member Services at **1-800-832-4643**, TTY **711**, 8 a.m. – 8 p.m. EST, Monday – Friday.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

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

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

If you need help with your complaint, please call Member Services at **1-800-832-4643**, TTY **711**.

Services to help you communicate with us are provided at no cost to members, such as other languages or large print. Or, you can ask for an interpreter. To ask for help, please call Member Services at **1-800-832-4643**, TTY **711**, 8 a.m. – 8 p.m. EST, Monday – Friday.

ATTENTION: If you speak English language assistance services, free of charge, are available to you. Call **1-800-832-4643, TTY 711.**

ATENCIÓN: Si habla español (Spanish), tiene a su disposición servicios de asistencia gratuitos en su idioma. Llame al **1-800-832-4643, TTY 711.**

注意：如果您說中文 (Chinese)，您可獲得免費語言協助服務。請致電 **1-800-832-4643，聽障專線 (TTY) 711。**

HINWEIS: Wenn du Deutsch (German) sprichst, stehen dir kostenlose Sprachdienste zur Verfügung. Anrufe unter **1-800-832-4643, TTY 711.**

Attention: Vann du Pennsylvania Deitsh (Pennsylvania Dutch) shvetsht, dann kansht du hilf greeya funn ebbah es deitsh shvetzt, un's kosht dich nix. **Call 1-800-832-4643, TTY 711.**

သတိမူရန်- သင်သည် မြန်မာ (Burmese) စကားပြောတတ်လျှင်၊ ဘာသာစကားအကူအညီအား အခမဲ့ရယူနိုင်ပါသည်။ ခေါ်ဆိုရန် **1-800-832-4643, TTY 711.**

تنبيه: إذا كنت تتحدث العربية (Arabic)، فتتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم **1-800-383-2464، الهاتف النصي 711 TTY.**

참고: 한국어(Korean)를 구사하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-800-832-4643(TTY는 711)번으로 문의하십시오.**

LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-800-832-4643, TTY 711.**

ATTENTION : si vous parlez français (French), vous pouvez obtenir une assistance linguistique gratuite. Appelez le **1-800-832-4643, TTY 711.**

注意：日本語 (Japanese) 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 **1-800-832-4643、または TTY 711 までご連絡ください。**

LET OP: Als u Nederlands (Dutch) spreekt, kunt u gratis gebruikmaken van taalhulpdiensten. Bel **1-800-832-4643, TTY 711.**

ATENSYON: Kung nagsasalita ka ng Tagalog (Tagalog), may magagamit kang mga serbisyo na pantulong sa wika na walang bayad. Tumawag sa **1-800-832-4643, TTY 711.**

ВНИМАНИЕ: Если Вы говорите по-русски (Russian), Вы можете бесплатно воспользоваться помощью переводчика. Позвоните: **1-800-832-4643, TTY 711.**

ਸਾਵਧਾਨ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। **1-800-832-4643, TTY 711 ਤੇ ਕਾਲ ਕਰੋ।.**

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-832-4643, TTY 711** पर कॉल करें।.