PDP Prescription Drug Plan
Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription label receipt(s) within 90 days.**

Please make and retain a copy of the receipts for your records.

Cash register and credit card receipts alone are not acceptable as proof of purchase.

Claims are reviewed, subject to limitations, exclusions and other provisions of the Plan Benefit.

Reimbursement is not guaranteed.

Patient Information (Complete one form per member)

Health Plan/Insurance Name & State *(please print)*	Group Employer/Name	
Name *(Last Name, First Name, Middle Initial)*	Birth Date	I.D. Number
Mailing Address *(Number, Street, City, State & Zip Code)*		
Prescribing Physician's Name	Physician's DEA or NPI number.(Obtain from physician)	Physician's Telephone Number

Reason For Request

Write the reason here:

Coordination of Benefits

(If your primary insurance has already paid for the attached prescription and you are seeking additional reimbursement, please complete this section.)

An Explanation of Payment from the primary insurance must include the dollar amount paid by the primary insurance.

Primary Health Plan/ Insurance Company Name _____

Primary Member/Subscriber's Name *(Last Name, First Name, Middle Initial*_____

Vaccine and Vaccine Administration

- ☐ Filled at pharmacy, and administered at physician's office
- ☐ Filled and administered at pharmacy
- ☐ Filled and administered at physician's office

Check below all that apply to the cost of the claim

- ☐ Administration Cost
- ☐ Vaccine Cost

Compound Prescriptions Only (Pharmacist must complete and sign)

- List the VALID 11 digit NDC number (highest to lowest cost) in the box at the right for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be provided with claim form

Rx#		Date Filled		Days' Supply	

Valid 11 digit NDC#	Quantity
Total Quantity	
Total Charge	

Signature of Pharmacist X _____

I certify that the patient for whom this claim is made is a covered person 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.

Member's/Subscriber's Signature X _____ Date _____

Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.

- Pharmacy Name
- Drug name, strength, and quantity
- Prescribing physician's name
- Prescription number and date filled
- Member paid expense

Please mail label receipt(s) and this completed form to:

OptumRx
P.O. Box 29046
Hot Springs, AR 71903

Reimbursement and correspondence will be issued to the primary member/subscriber.