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). Cash register and credit card receipts alone are not acceptable as proof of purchase. Reimbursement is not guaranteed.

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

**Prescription Solutions by OptumRx**

**Direct Member Reimbursement Form**

Contact us at 866-422-8272 or online at www.optumrx.com.

**Reason For Request**

Write the reason here:

**Coordination of Benefits**

(If your primary insurance has already paid for the attached prescription, please complete this section.)

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

**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

<table>
<thead>
<tr>
<th>Rx#</th>
<th>Date Filled</th>
<th>Days’ Supply</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

Valid 11 digit NDC# | Quantity
---|---

<table>
<thead>
<tr>
<th>Total Quantity</th>
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<table>
<thead>
<tr>
<th>Total Charge</th>
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</tbody>
</table>

**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

The claim(s) will be returned if the member/ subscriber’s signature is not present.

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

Prescription Solutions by OptumRx

P.O. Box 29044

Hot Springs, AR 71903

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