

**DIRECTIONS:**

1. Complete and sign claim form below. Use a separate form for each patient.
2. Send completed Form & Pharmacy receipts to:  
**Optum Rx Claims Department**, PO Box 650334, Dallas, TX 75265-0334

## 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

RxGroup (see ID card)		Member ID (see ID card)	
Last name	First name	MI	
Mailing street address			Apt. #
City	State	ZIP	
Prescription is for <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		Date of Birth (mm/dd/yyyy)	

### 2. Custodial parent information

For reimbursement requests from a parent for a child (under the age of 18) when the requesting parent meets both of the following requirements:

1. Parent is not enrolled in the same Group Health plan as the child
2. Parent does not reside in the same household as the subscriber under the child's Group Health plan

**If your child is covered under two or more health plans, state law determines the order of benefits for processing claims.**

Legal custodian's name	Legal custodian's contact phone
Custodian requesting reimbursement name	Custodian requesting reimbursement contact phone
Address payment is to be mailed to	

### 3. Physician and pharmacy information

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

### 4. Reason for request Select appropriate options for your request

- |  |  |
|--|--|
| <input type="checkbox"/> I did not use my Prescription Drug ID card  | <input type="checkbox"/> I filled a compound prescription (your pharmacist must complete section C on the back of this form) |
| <input type="checkbox"/> My primary coverage is with another insurance carrier (coordination of benefits claim; see section D on back for details) | <input type="checkbox"/> I was waiting for a drug approval   |
| <input type="checkbox"/> I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare                                     | <input type="checkbox"/> I purchased medication outside of the United States Country _____                                   |
| <input type="checkbox"/> I am submitting a copay receipt   | Currency used _____  |
| <input type="checkbox"/> I used a non-participating pharmacy (please explain)  | <input type="checkbox"/> Other (please explain)  |
| <input type="checkbox"/> My pharmacy billed the wrong plan   |  |
| <input type="checkbox"/> I purchased an OTC Contraceptive (see section B)  |  |

### 5. Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in Section A (below). If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
2. OTC Contraceptive receipts must contain all the information in Section B.
3. Read the Acknowledgement (section 5) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
4. Send completed form with pharmacy receipt(s) to: **Optum Rx Claims Department, PO Box 650334, Dallas, TX 75265-0334**

## Section A – Pharmacy receipts for reimbursement

☐ Date prescription filled     
 ☐ National Drug Code (NDC) number     
 ☐ Prescription number (Rx number)  
☐ Name and address of pharmacy     
 ☐ Name of drug and strength     
 ☐ Quantity  
☐ Prescribing physician name or ID number

☐ Date purchased \_\_\_\_\_

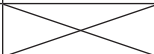
☐ Name of contraceptive purchased \_\_\_\_\_

☐ Quantity (e.g. one box, 28 pills, etc.) \_\_\_\_\_

☐ Where item was purchased \_\_\_\_\_

☐ Confirm price paid \_\_\_\_\_

- List VALID 11 digit NDC number (highest to lowest cost) in the box at right. Include EACH ingredient used in 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 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#		Date Filled		Days Supply	
VALID 11 digit NDC#			Quantity*	Ingredient Cost†	
Compounding Fee					
Total					

## Section D – Coordination of benefits

**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 receipts, and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the Primary Plan or Medicare.

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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.\*

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