Florida Health Care Plans®

An Independent Licensee of the Blue Cross and Blue Shield Association

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 ☐ Self ☐ Spouse ☐ 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

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

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: _____

Instructions for submitting form

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**

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.

Section A – Pharmacy receipts for reimbursement

Use the following checklist to ensure your receipts have all information required for your reimbursement request:

☐ 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

Section B – Receipts for OTC contraceptives

Use the following checklist to ensure your receipts have all information or that you have entered it in the space provided. All this information is required for your OTC Contraceptive reimbursement request:

☐ Date purchased _____
☐ Name of contraceptive purchased _____
☐ Quantity (e.g. one box, 28 pills, etc.) _____
☐ Where item was purchased _____
☐ Confirm price paid _____

Section C – Pharmacy information (for compound prescriptions ONLY)

(Pharmacist must complete and sign)

- 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		

X _____
Signature of Pharmacist

Section D – Coordination of benefits

You must submit claims within one year 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 receipts, and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the Primary Plan or Medicare.

When submitting 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 receipts showing the amount you paid at the pharmacy. These receipts will serve as the EOB.

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.*

Florida Health Care Plans has contracted with OptumRx, an independent and separate company, to provide direct member reimbursements. Florida Health Care Plan, Inc. d/b/a Florida Health Care Plans ("FHCP") offers health insurance coverage products. FHCP is an affiliate of Blue Cross and Blue Shield of Florida, Inc. d/b/a Florida Blue. Both companies are Independent Licensees of the Blue Cross and Blue Shield Association. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. You may access the Nondiscrimination and Accessibility notice here.