



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 650287, Dallas, TX 75265-0287

Medicare Part D Claim 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

| | | | | |
|-------------------------|--|-------------------|-----|----------------------------|
| Member ID (see ID card) | | Health plan name | | |
| Group/Employer name | | Health plan state | | |
| Last name | | First name | | MI |
| Mailing street address | | | | Apt. # |
| City | | State | ZIP | Date of Birth (mm/dd/yyyy) |

2. Physician and pharmacy information

| | | | | |
|---|--|--------------------------------------|--|--|
| Prescribing physician name | | Pharmacy name | | |
| Prescribing physician phone number with area code | | Pharmacy phone number with area code | | |

3. Reason for request Select appropriate options for your request

| | |
|---|---|
| Filled not using a prescription ID card <input type="checkbox"/> YES <input type="checkbox"/> NO Covered under another health plan <input type="checkbox"/> YES <input type="checkbox"/> NO • If yes, is this other plan Primary <input type="checkbox"/> YES <input type="checkbox"/> NO • If primary, include the explanation of benefits (EOB), primary health plan name: _____ • See section C on back of form – Coordination of benefits My pharmacy billed the wrong plan <input type="checkbox"/> YES <input type="checkbox"/> NO A compound prescription <input type="checkbox"/> YES <input type="checkbox"/> NO (Pharmacist must fill out Section B on back of form) Retroactively enrolled with the plan <input type="checkbox"/> YES <input type="checkbox"/> NO Filled while waiting for drug approval <input type="checkbox"/> YES <input type="checkbox"/> NO | Filled at a non-network pharmacy: • Illness while traveling outside of service area <input type="checkbox"/> YES <input type="checkbox"/> NO • Network pharmacy/mail order pharmacy within reasonable driving distance could not fill in a timely manner <input type="checkbox"/> YES <input type="checkbox"/> NO • While a patient at a health care facility (emergency dept., provider clinic, outpatient surgery) <input type="checkbox"/> YES <input type="checkbox"/> NO • Due to federal or state emergency/natural disaster <input type="checkbox"/> YES <input type="checkbox"/> NO |
|---|---|

4. Acknowledgement

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

X _____ **Date** _____
Member or authorized representative signature

NOTE: If form is completed and signed by an Authorized Representative rather than the member, an Authorization of Representation (AOR) must accompany the request or Power of Attorney (POA) must be on file with the plan.

Optum Rx administers Direct Member Reimbursements for Florida Blue Medicare, Inc., DBA FHCP Medicare. HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an Independent Licensee 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. View the Discrimination and Accessibility Notice at fhcpmedicare.com/ndnotice_ENG plus information on our free language assistance services. Or call 1-833-866-6559 (TTY: 1-800-955-8770). Puede ver la notificación de discriminación y accesibilidad, además de información sobre nuestros servicios gratuitos de asistencia lingüística en fhcpmedicare.com/ndnotice_SPA. O llame al 1-833-866-6559 (TTY: 1-877-955-8773).