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**

<table>
<thead>
<tr>
<th>RxGroup (see ID card)</th>
<th>Member ID (see ID card)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name</td>
<td>First name</td>
</tr>
<tr>
<td>Mailing street address</td>
<td>Apt. #</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>ZIP</td>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Prescribing physician name</th>
<th>Dispensing pharmacy name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing physician phone number with area code</td>
<td>Dispensing pharmacy phone number with area code</td>
</tr>
</tbody>
</table>

4 **Reason for Request** Select appropriate options for your request

- I did not use my Prescription Drug ID card
- I used a non-participating pharmacy (please explain)
- I filled a compound prescription (your pharmacist must complete section B on the back of this form)
- I purchased medication outside of the United States
- My primary coverage is with another insurance carrier (coordination of benefits claim; see section C 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 was waiting for a drug approval
- I was retroactively enrolled with the plan
- My pharmacy billed the wrong plan
- 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: ________________

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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. 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.

3. Send completed form with pharmacy receipt(s) to: OptumRx 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 – 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.

X Signature of Pharmacist

Section C – 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.*

*Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.

*California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

All Commercial HMO products are underwritten by Memorial Hermann Commercial Health Plan, Inc.
All Commercial PPO products are underwritten by Memorial Hermann Health Insurance Company.
All Hybrid products are administered by Memorial Hermann Health Solutions, Inc.
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.855.645.8448 (TTY 711).</td>
</tr>
<tr>
<td>Japanese</td>
<td>注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.855.645.8448（TTY 711）まで、お電話にてご連絡ください。</td>
</tr>
<tr>
<td>Cantoneese Chinese</td>
<td>注意：如果您說廣東話，您可以免費獲得語言援助服務，請致電1.855.645.8448（TTY 711）。</td>
</tr>
<tr>
<td>Korean</td>
<td>주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.855.645.8448 (TTY 711) 번으로 전화해 주십시오.</td>
</tr>
<tr>
<td>Mandarin Chinese</td>
<td>注意: 如果您说普通话，您可以免费获得语言援助服务。请致电1.855.645.8448（TTY 711）。</td>
</tr>
<tr>
<td>Laotian</td>
<td>โปรดทราบ: ถ้าคุณพูดภาษาลาว, บริการความช่วยเหลือภาษาฟรีมีพร้อมอยู่ โทร 1855.645.8448 (TTY 711)</td>
</tr>
<tr>
<td>Russian</td>
<td>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.855.645.8448 (телетайп 711).</td>
</tr>
<tr>
<td>Gujarati</td>
<td>જો તમે ગુજરાતી બોલતા હો તો, તે નોંધવો કાફી સહાય મળશે અને તમારી માટે ઉપયોગી હોઈ શકે. કોસ્ટ ટંક 1.855.645.8448 (TTY 711).</td>
</tr>
<tr>
<td>Hindi</td>
<td>ध्यान दें: यदि आप हंगाम हृदि बोलते हैं तो आपके लिए मुफ्त में माहा सहायता मिलेगी. 1.855.645.8448 (TTY 711) पर कॉल करें</td>
</tr>
<tr>
<td>Urdu</td>
<td>خبردار: اگر آپ اردو بولتے بھی تو آپ کو زبان کی مدد کی خدمات مفت میں استیبل پہنچ سکتے ہوئے، کال کریں 1.855.645.8448 (TTY 711).</td>
</tr>
</tbody>
</table>

**ATTENTION:** Texas Relay Services are available for the hearing impaired at (711). Resources are available for the visually impaired, please call 1.855.645.8448 (711).
Memorial Hermann Health Plan, Inc., Memorial Hermann Health Insurance Company, Memorial Hermann Commercial Health Plan, Inc. and Memorial Hermann Health Solutions, Inc. (collectively “MHHP”) comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Memorial Hermann Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MHHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (855) 645-8448.
Customer Service Hours of Operations: 8am-5pm (CST) M-F

If you believe that MHHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Memorial Hermann Health Plan
929 Gessner Road, Suite 1500
Houston, TX 77024

Fax 713-338-6487
Email MHHHealthAppeals@memorialhermann.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, (1-800-537-7697 TDD).