Optum Rx®

UnitedHealthcare®

Non-Participating Pharmacy Prescription cost share form

Use this form to request application of payment amount to the deductible and out of pocket maximum for covered medications purchased at retail pharmacy, following state law requirements. Complete one form per member.

Please print clearly. Additional information and instructions on back, please read carefully.

Member Information	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 application of payment 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 application of payment name	Custodian requesting application of payment contact phone
Address payment is to be mailed to	

3. Provider and pharmacy information

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

4. Reason for request Select appropriate options for your request

☐ I used a non-participating pharmacy and paid a price lower than the health plan cost share at a network pharmacy.

☐ The cost share at a network pharmacy payment for this drug _____

☐ The price you paid for the drug that you received _____

☐ Confirmation of the amount that you paid out-of-pocket for the drug received ☐ Yes ☐ No

* Any applicable clinical criteria must be met as if the drug had been filled at a network pharmacy.

* Texas only - The drug that was negotiated for a lower cost at a non-participating pharmacy must be medically necessary.

5. Acknowledgement

I certify that the medication(s) for which application of payment 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 under the health plan. I also certify that the medication(s) received were not for treatment of an on-the-job injury. I recognize **application of payment** will be **applied** directly to my **deductible and out of pocket maximum** 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. Read the Acknowledgement (section 5) on the front of this form carefully. Then sign and date.
3. Send completed form with pharmacy receipt(s) to: **OON_mandate_claim_submission@optum.com**

Note: Cash and credit card receipts are not proof of purchase. A pharmacy receipt is NOT a register receipt. Incomplete forms may be returned and delay application of payment. Application of payment to the deductible and out of pocket maximum is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Section A – Pharmacy receipts of payment

Use the following checklist to ensure your receipts have all information required for your application of payment 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 provider 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.

Rx#		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity*	Ingredient Cost†
Compounding Fee		
Total		

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. A pharmacy receipt is NOT a register receipt.

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.

請注意：如果您說中文 (Chinese)，公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通，我们提供一些免费服务，例如用其他语言书写的信件或大字体。您也可以要求与口译员对话。欲寻求帮助，请拨打您的 ID 卡上列出的免费电话号码。