UnitedHealthcare®
PacifiCare®

Prescription Drug Program
Direct Member Reimbursement Form

Instructions

1. Complete and return this form when you have purchased a covered and prescribed prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription/label receipts to expedite processing**. A cash register receipt alone is not acceptable as proof of purchase.
2. Prescription receipt/labels must have the following information clearly legible, or payment can be delayed or denied:
   - Pharmacy name
   - Prescription number and date filled
   - Prescribing physician's name
   - Drug name, strength and quantity
   - Member expense
3. This claim will be returned if the member/subscriber signature is not present.
4. Please mail these receipts/labels and this completed form to the address at the bottom of the form.
5. All payments and correspondence will be issued to the primary member/subscriber.

Patient Information (one form per patient)

Health Plan/Insurance Name & State (please print)	Group/Employer Name	Union Trust # (if applicable)
Name (Last Name, First Name, MI)	Birth Date	ID #/ HIC #
Mailing Address (Number, Street, City, State & Zip Code)		Social Security #
Prescribing Physician's Name		Physician's Telephone Number

Reason for Request (at least one must be checked)

- ☐ Out-of-Area urgent/emergency medication
- ☐ Non-urgent medication/vacation request
- ☐ No identification card or identification number available
- ☐ Eligible member/group invalid
- ☐ Coordination of Benefits (with primary insurance)
- ☐ Referral or non-contracting physician/self-referral
- ☐ Compound medication
- ☐ Non-contracted pharmacy
- ☐ Other ____

Coordination of Benefits (if your primary insurance has already paid for the prescription, please complete this section)

Primary Health Plan/Insurance Company	Spouse's Name (Last Name, First Name, MI)	Spouse's Number

I certify that the patient for whom this claim is made is a covered person 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 workers' 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 ____

Member's/Subscriber's Signature Date

Prescription Solutions
Mail Stop LC07-290
Attn: Claims Dept.
P.O. Box 6037
Cypress, California 90630-0037

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