MEMBER REIMBURSEMENT DRUG CLAIM FORM

Coverage provided by Kaiser Foundation Health Plan of Washington and
Kaiser Foundation Health Plan of Washington Options, Inc.

OPTUMRx®

KAISER PERMANENTE®

Complete this form, attach prescription labels and mail to: OptumRx, PO Box 968022, Schaumburg, IL 60196-8022

Cardholder Information

Cardholder's ID Number:	Group / Employer / Name and Number:
Cardholder's Name: (Last, First, Middle)	Cardholder's Birthdate: (MM/DD/YYYY)
Cardholder's Address: (Street, City, State, Zip)	Cardholder's Telephone Number: ( )

Patient Information

Prescription(s) were for:

Patient Name: (First, Middle, Last)	Gender: ☐ Male ☐ Female	Employee ☐	Spouse ☐	Dependent ☐	Patient Birthdate (MM/DD/YYYY)

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 Kaiser Permanente Health plan as the child
2. Parent does not reside in the same household as the subscriber under the child's Kaiser Permanente 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:

Reason for Request

- ☐ Coordination of benefits with primary pharmacy or medical plan.
- ☐ Compound claim
- ☐ Out of area / urgent / emergency request
- ☐ Eligibility issue at the pharmacy
- ☐ Other, please describe:

Pharmacy Information

Pharmacy Name:	Pharmacy NABP Number:
Pharmacy Address: (Street, City, State, Zip)	
Pharmacy Telephone Number: ( )	Pharmacist Signature: Date:

Continued on reverse

Prescription Information

Please include the **prescription labels** *with this form (receipts are not acceptable) or a pharmacy printout signed by the pharmacist. You can ask your* **pharmacist** *for assistance in completing the information below. Completing this entire form will result in timely processing of your claim. For questions concerning this claim please call the toll free number listed on your pharmacy ID card.*

❶ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)	
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #	Rx Price Paid:
❷ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)	
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #	Rx Price Paid:
❸ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)	
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #	Rx Price Paid:

I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Signature: Date: