Prescription Drugs Payment Request Form

Member Information

Name (First, Middle, Last):	
Member ID (CIN):	
Phone Number:	
Address where you live:	Address:
City, State, ZIP code:	City: State: ZIP code:
Address where you want to receiveyour check: (if different from where you live)	Address:
City, State, ZIP code:	City: State: ZIP code:

Payment Request #1: Prescription Drug Information

Name of drug:	
Strength of drug: (if known)	
Quantity of drug: (if known)	
Date prescription was filled:	
Amount paid:	$
Pharmacy Name:	
Pharmacy Phone Number:	
Why did you pay for this drug?	
Did you attach the receipt?	☐ Yes ☐ No

Payment Request #2: Prescription Drug Information

Name of drug:	
Strength of drug: (if known)	
Quantity of drug: (if known)	
Date prescription was filled:	
Amount paid:	$
Pharmacy Name:	
Pharmacy Phone Number:	
Why did you pay for this drug?	
Did you attach the receipt?	☐ Yes ☐ No

Payment Request #3: Prescription Drug Information

Name of drug:	
Strength of drug: (if known)	
Quantity of drug: (if known)	
Date prescription was filled:	
Amount paid:	$
Pharmacy Name:	
Pharmacy Phone Number:	
Why did you pay for this drug?	
Did you attach the receipt?	☐ Yes ☐ No

If you have more than 3 requests, please attach additional pages as needed.
I certify that the information on this request form is correct to the best of my knowledge.

Submit request to:
CalOptima Health OneCare Complete (HMO D-SNP)
Pharmacy Management Reimbursement
505 City Parkway West
Orange, CA 92868
Fax: 1-858-357-2556

Signature: _____

Date: _____

Requestor's Information

Complete this page ONLY if the person making this request is not the member.

Prescribers may make this request on behalf of the member. If the person making this request is another individual (such as a family member or friend), that individual must be the member's representative.

Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a similar written document). For more information on choosing a representative, contact CalOptima Health OneCare Complete Customer Service at **1-877-412-2734** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week (October 1 to March 31), and 8 a.m. to 8 p.m., Monday through Friday (April 1 to September 30). You can also call **1-800-MEDICARE**.

Name (First, Middle, Last):	
Relationship to the Member:	
Phone Number:	
Fax Number: (if applicable)	
Address where you get mail:	Address:
City, State, ZIP code:	City: State: ZIP code:
Did you attach documentation of representation?	☐ Yes ☐ No

CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, is a Medicare Advantage organization with Medicare and Medi-Cal contracts. Enrollment in CalOptima Health OneCare depends on contract renewal. Call CalOptima Health OneCare Customer Service toll-free at **1-877-412-2734** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week (October 1 to March 31), and 8 a.m. to 8 p.m., Monday through Friday (April 1 to September 30). Visit us at **www.caloptima.org/OneCare**.

Enclosures:

- Notice of Availability and Notice of Nondiscrimination Insert