To access a Direct Member Reimbursement form on the Internet, visit www.ucare.org.

Helpful Hints to Speed Up your Reimbursement

Did you include the following information?

- Member name and ID (identification) number.
- Actual pharmacy receipts and/or pharmacy print-outs showing payment information.
- The pharmacy's NPI (National Provider Indicator) number.
- The quantity and days supply for each prescription.
- The drug NDC (National Drug Code) number. (Located on the pharmacy receipt in most cases. If not, ask the pharmacist.)
- Your correct mailing address printed on the front of this form.
- Paid receipt(s).

Facts to know:

- Member reimbursements take approximately 30 days to process.
- Use this form every time you submit claim(s) for reimbursement.
- Save time by making copies of this form for future reimbursements.
- Member Services representatives are available 8 a.m. to 8 p.m., seven days a week.

Customer Services
612-676-3600 or 1-877-523-1515 (toll free)
TTY/TDD: 612-676-6810 or 1-800-688-2534 (toll free)
8 a.m. to 8 p.m., seven days a week

I hereby certify that the accompanying statements, are to the best of my knowledge true, correct, and complete. I hereby authorize any Physician or service provided to furnish and disclose all known facts concerning this claim, upon request from the claim administrator. I will reimburse the fund for any overpayment made to me or on my behalf due to error on this form.

____________________________ ________________________

MEMBER SIGNATURE DATE

Direct Member Reimbursement Form

Please read carefully and fill out the entire form.

Directions:

1. This form must be completely filled out in order to process your claim(s).
2. Attach all prescription receipt(s) to the back of this form.
3. Prescription receipts must contain all of the following information or they will not be accepted: Prescription number, paid receipts, date filled, Pharmacy NPI (National Provider Indicator) number, drug name with NDC (National Drug Code) number, strength, quantity, days supply, and amount paid.
4. If you have any questions, please call Member Services: 612-676-3600 or 1-877-523-1515 (toll free) or TTY/TDD 612-676-6810 or 1-800-688-2534 (toll free)
5. The form should be signed by the member and mailed to UCare's Pharmacy Benefit Manager at:

RxAmerica
Attn: MMA Claims
P.O. Box 22690
Salt Lake City, UT 84122-0690

Reason for Submitting Direct Member Reimbursement

Please explain: ____

____

UCare Member Information • Please Print

______________ ______________ ______________ ______________
Member Name (First, Last) Member ID Number Phone Date of Birth

____
Street Address Apt.

______________ ______________ ______________
City State Zip Code

Prescription Information

Rx Number	Date Rx Filled	Pharmacy NPI#	Drug Name and NDC Number	Strength	Quantity	Days Supply	Amount You Paid

Vaccine Information

Rx Number	Date of Admin	Provider NPI #	Vaccine Name				Amount You Paid

For Office Use Only
Entered by: ______ Date: ______ Quality Auditor: ______ Date: ______ Scanned by: ______ Date: