Direct Member Refund Form

You must fill out this entire form for us to process your claim(s).

1. Attach all prescription (Rx) receipt(s) to the back of this form.

2. The receipt(s) must have the following:
   - Rx number
   - Date filled
   - Store name
   - Doctor name
   - Rx name
   - Strength
   - Amount you paid

Store cash receipt(s) will not be accepted.

3. Sign form and mail receipt(s) to:
   Molina Healthcare, Senior Whole Health of New York, Passport Advantage by Molina Healthcare, My Choice Wisconsin, ConnectiCare, or Central Health Medicare Plan
   Attention: Pharmacy Department
   7050 Union Park Center Suite 600
   Midvale, UT 84047

If you have any questions please call Member Services at (800) 665-3086 TTY users should call 711, October 1 – March 31: 7 days a week, 8 a.m. to 8 p.m., local time, April 1 – September 30: Monday – Friday, 8 a.m. to 8 p.m., local time.

Member details:

Member Name: _____ Date of Birth: _____

Member ID Number: _____ Phone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Rx Information:

Rx Number	Date Rx Filled	Drugstore Name & NPI Number	Drug Name	Strength	Number & Day Supply	Amount You Paid

Rx Number	Date Rx Filled	Drugstore Name & NPI Number	Drug Name	Strength	Number & Day Supply	Amount You Paid

Notice of Availability (NOA)