**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 |
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Notice of Availability (NOA)