



**Direct Member Reimbursement Form**

**Directions: Please read and fill out the entire form.**

1. You must fill out this entire form in order for us to process your claim(s)
2. Attach all prescription receipt(s) to the back of this form
3. The receipt(s) must have all of the following information:
  - Rx number
  - date filled
  - pharmacy name
  - physician name
  - drug name
  - strength
  - quantity and prescription charge

\*\*\*\*Store cash register receipt(s) will not be accepted. The receipt(s) **MUST** contain the above information\*\*\*\*

4. Sign form and mail receipt(s) to:
 

Molina Dual Options MI Health Link  
 Medicare-Medicaid Plan  
 Attention: Pharmacy Department  
 7050 Union Park Center Suite 200  
 Midvale, UT 84047

5. If you have any questions or concerns please call Member Service at (855) 735-5604, TTY users should call 711. We are available, Monday - Friday, 8a.m. to 8p.m., ET.

**Member Information: (This is the individual considered to be the cardholder.) Please Print**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

**Prescription Information:**

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

Molina Dual Options MI Health Link Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

You can get this document for free in other formats, such as large print, braille, or audio. Call (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., ET. The call is free.

Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability, geographic location.

<https://www.molinahealthcare.com/members/common/en-US/multi-language-taglines.aspx>

H7844\_NSR\_19\_292\_MIMMPDMRForm 9/19/2018

# Mail Service Order Form

Mail this form to:



CVS Caremark  
PO BOX 659541  
SAN ANTONIO, TX 78265-9541

Member ID # (if not shown or if different from above)

Prescription Plan Sponsor or Company Name

**Instructions:**

Please use **blue or black ink** and **print in capital letters**. Fill in **both sides** of this form.

**New Prescriptions** – Mail your new prescriptions with this form.

Number of **New** prescriptions:

**Refills** – Order by Web, phone, or write in Rx number(s) below.

Number of **Refill** prescriptions:

**TO RECEIVE YOUR ORDER SOONER** request refills or new prescriptions online at [www.caremark.com](http://www.caremark.com) or call the toll-free number on your member ID card.

**A Shipping Address.** To ship to an address different from the one printed above, enter the changes here.

Last Name

First Name

MI

Suffix (JR, SR)

Street Address

Apt./Suite #

Use shipping address for this order only.

City

State

ZIP Code

Daytime Phone #:  -  -

Evening Phone #:  -  -

**B Refills.** To order mail service refills, enter your prescription number(s) here.

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

5) \_\_\_\_\_ 6) \_\_\_\_\_ 7) \_\_\_\_\_ 8) \_\_\_\_\_

CVS Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

We may package all of these prescriptions together unless you tell us not to.

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.



Please fold here →

Please fold here →

Please fold here →

Please fold here →

**C Tell us about the people ordering prescriptions.** If there are more than two people, please complete another form.

**First person with a refill or new prescription.**

Spanish forms and labels

LAST NAME

FIRST NAME

M Suffix (JR,SR)

NICKNAME

Date of birth: MM-DD-YYYY

E-mail address: \_\_\_\_\_ Date new prescription written: \_\_\_\_\_

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new health information for 1st person if never provided or if changed.

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfa  Other: \_\_\_\_\_

Medical conditions:  Arthritis  Asthma  Diabetes  Acid reflux  Glaucoma  Heart problem  High blood pressure  High cholesterol  Migraine  Osteoporosis  Prostate issues  Thyroid  Other: \_\_\_\_\_

**Second person with a refill or new prescription.**

Spanish forms and labels

LAST NAME

FIRST NAME

M Suffix (JR,SR)

NICKNAME

Date of birth: MM-DD-YYYY

E-mail address: \_\_\_\_\_ Date new prescription written: \_\_\_\_\_

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new health information for 2nd person if never provided or if changed.

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfa  Other: \_\_\_\_\_

Medical conditions:  Arthritis  Asthma  Diabetes  Acid reflux  Glaucoma  Heart problem  High blood pressure  High cholesterol  Migraine  Osteoporosis  Prostate issues  Thyroid  Other: \_\_\_\_\_

**D Special instructions:** \_\_\_\_\_

**E How would you like to pay for this order?** (If your copay is \$0, you do not need to provide payment information.)

**Electronic check.** Pay from your bank account. (You must first register online or call Customer Care.)

**Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

Use your card on file.

Use a new card or update your card's expiration date.

CARD NUMBER Exp. Date MMY Y

**Check or money order.** Amount: \$ \_\_\_\_\_ . \_\_\_\_\_

Credit card holder signature/Date

- Make check or money order payable to CVS Caremark.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to \$40.

**Payment for balance due and future orders:** If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

**Regular delivery is free** and takes up to 5 days after your order is processed.

**If you want faster delivery, choose:**

**2nd business day (\$17)**

Faster delivery can only be sent to a street address, not a PO Box

**Next business day (\$23)**

**Expected processing time from receipt of this form:**

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charges subject to change)



Please fold here →

Please fold here →

Please fold here →

Please fold here →