

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:
 - Prescription 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 Medicare-Medicaid Plan
Attention: Pharmacy Department
7050 Union Park Center Suite 600
Midvale, UT 84047

5. If you have any questions or concerns please call Member Services at (855) 735-5831, TTY users should call 711. We are available, 7 days a week, 8 a.m. to 8 p.m., local time.

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:

Prescription Number	Date Prescription Filled	Pharmacy Name & National Provider Identifier Number	Drug Name	Strength	Quantity & Day Supply	Amount You Paid

Molina Dual Options Medicare-Medicaid Plan is a health plan that contracts with both Medicare and South Carolina Healthy Connections 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) 735-5831, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time. The call is free.

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