MOLINA HEALTHCARE

Direct Member Reimbursement Form

Directions: Please read and fill out the entire form.

1. This form must be completely filled out in order to process your claim(s). Please be thorough.
2. Attach all prescription receipt(s) to the back of this form.
3. Prescription receipt(s) must contain 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 Medicare Choice Care HMO
Attention: Pharmacy Department
7050 Union Park Center Suite 200
Midvale, UT 84047

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

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

This information is available in other formats, such as Braille, large print, and audio.