CareOregon Advantage

Please submit complete forms and attachments to:
CareOregon Advantage Attention Pharmacy DMR
PO Box 40328 Portland, Oregon 97240-0328 **OR**
315 SW 5th Avenue Portland, Oregon 97204-9922

DIRECT MEMBER REIMBURSEMENT FORM

Please check that the information on this form is complete and legible. If the decision for coverage is favorable you will receive notice and applicable payment within 14 days from the date that we receive the request.

To help us process the request, please include the following: I. Copy of Prescription Labels **AND** Proof of payment (Register Receipt); **OR II**. Pharmacy printout signed by a pharmacist with the completed form. Please retain copies for your record(s).

Please select reason(s) for request(s):

□ No Insurance card at the time of drug purchase
□ Unable to obtain drug due to driving distance
□ Drug is out of stock at a network pharmacy
□ Retroactive enrollment into the plan
□ Other:_____
□ Traveling within US or its territories – no network pharmacy
□ Primary coverage is with another insurance, include explanation of benefits from other plan and copay receipt
□ Level of care change (e.g. hospital discharge, discharge from long-term care, hospice stay ended, etc): _____

1. MEMBER INFORMATION

Last Name:	First Name:		DOB:
Member ID:	Gender:	Phone:	
Address:	City:	State:	Zip:

2. PERSON COMPLETING THE FORM □ Same as member above □ Parent/Legal Guardian

Name:		Phone:	
Address:	City:	State:	Zip:

3. PHARMACY INFORMATION

Name:		Phone:	
Address:	City:	State:	Zip:

4. REQUESTED DRUG(S) FOR REIMBURSEMENT

Date of Service	Quantity	Medication Name, Strength and Form	Day Supply	Amount
1.				
2.				
3.				
4.				
			Total:	

5. PERSON COMPLETING THE FORM SIGNATURE

By signing this form below, I certify that all information provided on this form is correct to the best of my knowledge; the prescription(s) submitted are for me or members of my family who are eligible and are for the sole use of the named member above. I authorize release of any eligible contact to the pharmacy and doctor office as necessary to obtain information pertaining to this claims(s) to CareOregon and I understand that fraudulent acts (including false claims) may be subjected to civil or criminal penalties.

Signature:	Date:

FOR CAREOREGON USE ONLY: Rec'd:_____ ☐ Completed ☐ Approved ☐ Denied ☐ Cancel/Member Ineligible

□ Eligibility_____ □ No duplicate claims □ QXNT □ DMR LOG □ Uploaded to DMS □ Processed through RxAuth
□ Pharmacy Labels and Proof of Purchase OR □ Pharmacy Printout with Pharmacist Signature □ Letter created for cancelled
□ Emailed OptumRx □ Manual Claim(s) processed through OptumRx Date:_____ □ Secondary Only □ LOB:_____