



Direct Member Reimbursement Form

Directions: Please read and fill out the entire form.

- 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
 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 CA 1-800-665-0898, WA 1-800-665-1029, MI 1-800-665-3072, TX 1-866-440-0012, NM 1-866-440-0127, UT 1-888-665-1328, OH 1-866-472-4584, FL 1-866-553-9494 TTY/TDD users should call 1-800-346-4128. We are available from Monday – Sunday, 8:00 AM to 8:00 PM 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

A Health Plan with a Medicare contract

A Coordinated Care plan with a Medicare Advantage contract and a contract with the state Medicaid program.