Soundpath HEALTH

Prescription Drug Reimbursement Instructions

Thank you for choosing Soundpath Health for your prescription drug coverage. Soundpath Health requires members to use their plan issued ID card to fill prescription drugs at network pharmacies who process claims electronically. This requirement ensures that members are charged the correct amount, have safety checks, and coordination of benefits with other payers, if applicable, in real time.

Prescription drug reimbursement requests should only be in cases of emergency when a Soundpath Health network pharmacy is not able to be used. Claim denials for claims refilled too-soon, non-formulary, or other safety related reasons, will not constitute an emergency and may result in the reimbursement request being denied.

To request a reimbursement for a medication not originally processed using your Soundpath Health card, there are a few things to keep in mind for the reimbursement process to go smoothly:

1. Use the attached claim form(s) for any prescription drug reimbursement requests you may have. Please read the attached form(s) carefully.
2. Claim forms that do not include the required information may delay or inhibit our ability to process your request for reimbursement.
3. Retain copies of receipts for your records. Receipts will not be returned.
4. Claims submitted for generic OTC allergy medications will not be reimbursed if your provider did not write a prescription for the medication and it was not processed by a pharmacy.
5. Please indicate the reason for requesting reimbursement on the attached form.
    a. *Please note that if the reason is due to Coordination of Benefits – Claims must be submitted with pharmacy receipt(s) identifying copays paid and an Explanation of Benefits from the primary carrier (or pharmacy prescription records showing primary insurance payment).*

Manual submission of claims does not guarantee reimbursement. If the prescription drug(s) is Non-formulary or has Prior Authorization, Step Therapy, Quantity Limits requirements or is restricted in some other way, we will make a Coverage Determination according to our Coverage Determination and Exceptions process.

Please submit completed form(s) and pharmacy receipts in one of the following ways:

1. Mail to: Optum Rx
PO Box 29044
Hot Springs, AR 71903
2. Fax to: 1-866-713-6511
3. Website: optumrx.com

MEMBER REIMBURSEMENT DRUG CLAIM FORM

Complete this form, attach prescription labels and mail to:

Soundpath Health
PO Box 29044
Hot Springs, AR 71903

Cardholder Information

Cardholder's ID Number:	Group/Employer/Union Name and Number:
Cardholder's Name: (Last, First, Middle)	Cardholder's Birthdate: (MM/DD/YYYY)
Cardholder's Address: (Street, City, State, Zip)	Cardholder's Phone Number:

Patient Information

Prescription(s) were for:

Patient Name: (First, Middle, Last)	Gender: ☐ Male ☐ Female	Employee ☐ Spouse ☐ Dependent ☐	Patient Birthdate: (MM/DD/YYYY)

Reason for Request

☐ Coordination of benefits with primary pharmacy or medical plan.
☐ Compound claim
☐ Out of area/ urgent/emergency request
☐ Eligibility issue at the pharmacy
☐ Other, please describe:

Pharmacy Information

Pharmacy Name:	Pharmacy NABP Number:
Pharmacy Address: (Street, City, State, Zip)	
Pharmacy Telephone Number: ( )	Pharmacist Signature: Date:

Prescription Information

Please include the **prescription labels** *with this form (receipts are not acceptable) or a pharmacy printout signed by the pharmacist. You can ask your* **pharmacist** *for assistance in completing the information below. Completing this entire form will result in timely processing of your claim. For questions concerning this claim please call the toll free number listed on your pharmacy ID card.*

❶ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits) | | | | | | | | | | |		
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #	Rx Price Paid:	
❷ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits) | | | | | | | | | | |		
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #:	Rx Price Paid:	
❸ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits) | | | | | | | | | | |		
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #:	Rx Price Paid:	

I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Signature: Date: