ArrayRx PO Box 40168
Portland, OR 97240-0168

Uniform Medical Plan

Uniform Medical Plan Prescription Drug Claim Form

This claim form can be used to request reimbursement of covered prescription drugs, vaccines received at a pharmacy, over the counter COVID-19 at home test kits, and compounded prescription drugs. Submit claims within 12 months of purchase and submit a separate form for each person for whom you are submitting receipts. Allow up to 15 business days for processing after we receive your claim. Any purchases made from an excluded pharmacy are not covered. CVS is an excluded pharmacy under your UMP prescription drug benefit. For any questions or assistance filling out this form, call ArrayRx at 1-888-361-1611 (TRS:711).

Parts to Complete on this Claim Form

- Prescriptions or vaccines received within the US – Complete Parts 1, 2, 3, and 4
- Prescriptions or vaccines received outside the US – Complete Parts 1, 2, 3, and 6
- Compounded prescription drugs – If you were given a separate claim form from the compounding pharmacy, complete Parts 1, 2, 3 and the "Preparation Time" in Part 5 of this form and attach that claim form to this form. If you were not given a separate claim form, complete Parts 1, 2, 3 and all of Part 5.
- COVID Test Kits - Complete applicable Parts for prescriptions filled inside or outside the US as indicated above, and Part 7

Indicate the reason for your reimbursement request.

☐ I did not have my member ID card at the time of purchase.
☐ Primary coverage is with another insurance carrier.
☐ Other: _____

Part 1: Member Information

1. Complete **ALL** information. Your ID Number is on the front of your member ID card.
2. Reimbursement will be issued to the member at the mailing address listed below.

Subscriber First Name	Subscriber Last Name	Subscriber MI
Member First Name	Member Last Name	Member MI
Telephone Number ( )	Date of Birth	Gender (Circle One) Male Female
Mailing Address		
City	State	Zip Code
Member's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent ☐ State Registered Domestic Partner		
ID Number W_____	Subscriber's Employer (PCN) ☐ Uniform Medical Plan Public Employees Benefits Board (PEBB) - NVTU ☐ Uniform Medical Plan School Employees Benefits Board (SEBB) - NVTU	
Member Signature		Date Signed

Part 2: Pharmacy Information

1. Complete **ALL** information.
2. Submit a separate form for each pharmacy from which you purchased prescription drugs.

Pharmacy Name		
Street Address		
City	State	ZIP Code
Pharmacy/or Provider of Service National Provider Number (NPI) (can be obtained from pharmacy)		Telephone Number ( )

Part 3: Receipt Information

1. Include Proof of Payment with the original pharmacy receipt(s)or pharmacy printout(s). Cash Register Receipt(s) without pharmacy detail will not be accepted. Tape all receipt(s) to the bottom of this page. **Do not staple**.
2. Receipt(s) must contain the information outlined under Part 4 (or Part 6 for prescriptions filled outside of the United States, or Part 7 for Over the Counter (OTC) COVID Test Kits). If your receipt(s) are missing any of this information, have your pharmacy provide you with a pharmacy receipt or pharmacy printout, that includes this information.
3. If you have primary coverage with another insurance carrier, provide both the explanation of benefits (EOB) and denial letter from the primary insurance carrier.
4. An incomplete form may be denied, delayed, or returned.
5. Receipts will not be returned. **Remember to keep a copy of the completed claim form and receipt(s) for your records.**

Part 4: Prescription Drug Information: This information should be listed in your original pharmacy receipt, or pharmacy printout. If the receipt or invoice is missing any of this information, ask your pharmacy to help fill in the missing details. If you are unable to obtain the information, we will attempt to contact your pharmacy. If you have more than one prescription, submit a separate "Part 4" for each medication.

Prescription Drug Name			
Date Rx Filled	Quantity	Day Supply	
Rx Number	National Drug Code (NDC)		
Prescriber First/Last Name		Prescriber NPI (Ask your provider)	
Original Cost of Rx	If there is other coverage for this member, provide the amount the Primary Insurance Paid on Rx		Member Paid Amount

Part 5: For Compounded Prescription Drugs only

1. The information in this section should be filled out by your compounding pharmacy.
2. **Note to Compounding Pharmacy:** It is important to include the **preparation time** below. Omission of the preparation time may result in a lower reimbursement.

Select the final form of Compound:		
☐ Cream ☐ Liquid ☐ Ointment	☐ Patch ☐ Suppository ☐ Suspension	☐ Other (Please specify): _____
Total Volume (grams, ml, each, etc.)		

Compound Ingredients

	Ingredient Name	Ingredient NDC	Metric Decimal Quantity	AWP/WAC (Ingredient Cost)
1				
2				
3				
4				
			Total Ingredient Cost	
			Preparation Time* (in minutes)	

***Compounding pharmacy preparation time spent preparing the compound drug**

Time	Reimbursement
1 – 4 minutes	$15.00
5 – 14 minutes	$25.00
15 – 29 minutes	$35.00
30 – 59 minutes	$50.00
60+ minutes	$75.00

Part 6: For prescriptions filled outside of the United States

Complete this section if your prescription was filled by a pharmacy outside of the United States. This information should be listed in your original pharmacy receipt, or pharmacy printout. If you have more than one prescription, submit a separate "Part 6" for each medication.

<table>
<tr><td>Rx Written Date</td><td>Date Rx Filled</td><td>Foreign Medication Name & Drug Strength</td></tr>
<tr><td>Rx Number</td><td colspan="2">U.S. Medication Name & Drug Strength</td></tr>
<tr><td colspan="2">U.S. National Drug Code (NDC)</td><td>Diagnosis Code / Description (What diagnosis or condition is medication being used to treat?)</td></tr>
<tr><td>Country Drug Was Purchased In</td><td>Quantity</td><td>Day Supply</td></tr>
<tr><td>Prescribing Physician First/Last Name</td><td colspan="2">Prescribing Physician NPI</td></tr>
<tr><td>Amount Paid in US Dollars</td><td>Rate of Exchange on Date of Purchase</td><td>If there is other coverage for this member, provide the amount the Primary Insurance Paid on Rx</td></tr>
</table>

Part 7: Over the Counter (OTC) COVID 19 At Home Test Kits

- Complete **ALL** information.

Date of Purchase	Product Name	
National Drug Code (NA if the code is not available)	Quantity of COVID Test/s in package	
Member Paid Amount		
Pharmacy/Online/Retailer Name		Telephone Number ( )
Street Address (or Website Address)		
City	State	ZIP Code

Part 8: Submitting Claim Form

Mail this form along with receipt(s) to:
Pharmacy Manual Claims
PO Box 999
Appleton, WI 54912-0999

Or Fax this form along with receipt(s) to:
Toll Free 1-855-668-8550