Prescription Drugs Payment Request Form

Member Information

Name (First, Middle, Last):	
Member ID (CIN):	
Phone Number:	
Address where you live:	Address:
City, State, ZIP code:	City: State: ZIP code:
Address where want to receive your check: (if different from where you live)	Address:
City, State, ZIP code:	City: State: ZIP code:

Payment Request #1: Prescription Drug Information

Name of drug:	
Strength of drug: (if known)	
Quantity of drug: (if known)	
Date prescription was filled:	
Amount paid:	$
Pharmacy Name:	
Pharmacy Phone Number:	
Why did you pay for this drug?	
Did you attach the receipt?	☐ Yes ☐ No

H8016_PD16_34 Accepted (1/15/16)

Payment Request #2: Prescription Drug Information

Name of drug:	
Strength of drug: (if known)	
Quantity of drug: (if known)	
Date prescription was filled:	
Amount paid:	$
Pharmacy Name:	
Pharmacy Phone Number:	
Why did you pay for this drug?	
Did you attach the receipt?	☐ Yes ☐ No

Payment Request #3: Prescription Drug Information

Name of drug:	
Strength of drug: (if known)	
Quantity of drug: (if known)	
Date prescription was filled:	
Amount paid:	$
Pharmacy Name:	
Pharmacy Phone Number:	
Why did you pay for this drug?	
Did you attach the receipt?	☐ Yes ☐ No

If you have more than 3 requests, please attach additional pages as needed.

I certify that the information on this request form is correct to the best of my knowledge.

Submit request to:
OneCare Connect
Pharmacy Management Reimbursements
505 City Parkway West
Orange, CA 92868
Fax: 1-858-357-2556

Signature: ____________________________

Date: _________________________________

Requestor's Information

Complete this page ONLY if the person making this request is not the member.

Prescribers may make this request on behalf of the member. If the person making this request is another individual (such as a family member or friend), that individual must be the member's representative.

Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or written equivalent). For more information on appointing a representative, contact Customer Service at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users should call **1-800-735-2929**. You can also call **1-800-MEDICARE**.

Name (First, Middle, Last):	
Relationship to the Member:	
Phone Number:	
Fax Number: (if applicable)	
Address where you get mail:	Address:
City, State, ZIP code:	City: State: ZIP code:
Did you attach documentation of representation?	☐ Yes ☐ No

OneCare Connect is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

This information is available for free in other languages. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

Esta información está disponible sin costo en otros idiomas. Por favor llame al Departamento de Servicios para Miembros al **1-855-705-8823**, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TDD/TTY deben llamar al **1-800-735-2929**.

Thông tin này có sẵn miễn phí bằng những ngôn ngữ khác. Xin vui lòng liên lạc Văn Phòng Dịch Vụ của chúng tôi ở số **1-855-705-8823**, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TDD/TTY có thể gọi ở số **1-800-735-2929**.

이 정보는 무료로 다른 언어로도 제공됩니다. 저희 고객 서비스 번호 **1-855-705-8823**으로 주 7일 24시간 전화주십시오. TDD/TTY 사용자는 번호 **1-800-735-2929** 로 전화하십시오.

این اطلاعات به طور مجانی, به زبانهای دیگر موجود است. لطفا با بخش خدمات مشتریان با شماره **1-855-705-8823**،
در طول 24 ساعت شبانه روز و 7 روز هفته تماس حاصل نمایید. کاربران TDD/TTY میتوانند با شماره
1-800-735-2929 تماس حاصل نمایند.