City of Racine
Pharmacy Reimbursement Claim Form

Instructions: Read carefully before completing the entire form. An incomplete form may delay your reimbursement. Please tape receipts to a **separate 8.5 x 11 sheet of paper on one side only. You may submit more than one sheet.**

Send form and receipts (separate 8.5 x 11 sheet of paper) to: UnitedHealthcare, P.O. Box 30555
Salt Lake City, UT 84130-0555

DX: R69 Tin: 0-069000002-00001 AOB = NO

Member/Subscriber Information (See your ID card.):

Medical Group Number: 712908

Member ID: _____ **Total Reimbursable Amount:** _____

Member Name (First, Last)

Street Address

City State Zip Code

Patient Information:

Patient Name (First, Last) Date of Birth (MM/DD/Year)

Gender: Female Male

Relationship to Member/Subscriber:

Self Spouse Eligible child Dependent Student
Disabled Dependent Other

Pharmacy Information

Name of Pharmacy Telephone (Including area code)

Street Address

City State Zip Code

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X_____
Signature of Member/Subscriber