OneCare Connect
CalOptima
A Public Agency
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Prescription Drugs Payment Request Form

Member Information

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

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 person (such as a family member or friend), that person 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). To learn more about 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:
Did you attach documentation of representation?	☐ Yes ☐ No

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.**Farsi:**

باشماره **1-855-705-8823** (**1-800-735-2929** :TTY) تماس بگیرید.

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم **1-855-705-8823** (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**).