OneCare (HMO SNP)
CalOptima
A Public Agency
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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

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 (HMO SNP)
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 **1-877-412-2734**, 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 (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal.

This information is available for free in other languages. Please call our Customer Service number at 1-877-412-2734, 24 hours, 7 days a week, for additional information. (TDD/TTY users should call 1-800-735-2929).

Esta información está disponible gratis en otros idiomas. Para más información, por favor llame al Departamento de Servicios para Miembros al 1-877-412-2734, las 24 horas al día, los 7 días de la semana. (Usuarios de la línea TDD/TTY pueden llamar al 1-800-735-2929).

Thông tin này cũng có sẵn miễn phí bằng những ngôn ngữ khác. Xin vui lòng liên lạc Văn Phòng Dịch Vụ của chúng tôi qua số điện thoại 1-877-412-2734 để biết thêm chi tiết. (Thành viên sử dụng máy TDD/TTY có thể liên lạc qua số 1-800-735-2929). Quý vị có thể liên lạc 24 giờ một ngày, 7 ngày một tuần.