

MEMBER COMPLAINT AND APPEAL FORM

NOTE: To obtain a review, submit a request in writing to the address below.

1 Primary insured *(Transcribe as seen on your OptumRx Plan ID card.)*

Today's date <i>(mm/dd/yyyy)</i>	Member's ID number	Plan type <input type="radio"/> Employee <input type="radio"/> Retiree
Member's first name	Middle initial <i>(MI)</i>	Member's last name
		Date of birth <i>(mm/dd/yyyy)</i>

2 Person you are submitting the request for *(if not the same as above)*

First name	Middle initial <i>(MI)</i>	Member's last name	Date of birth <i>(mm/dd/yyyy)</i>
Member's ID number			
Relationship to person requesting the appeal: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other _____			
<p>Note: If your selection is a spouse, child, or other (18 years of age or older), please complete and attach the HIPAA release form located at optumrx.com.</p>			

3 To help OptumRx review and respond to your request, please provide the following information *(This information may be found on correspondence from OptumRx.)*

Medication names	Rx number	Date of service
Explanation of your request <i>(Please use additional pages if necessary.)</i>		
<p>Note: When submitting this form with your request please include:</p> <input type="checkbox"/> Receipts and/or correspondence for the medication(s) <input type="checkbox"/> Any other helpful information		
Printed Name		
Signature		
Phone Number	Email	

You may mail your request to: OptumRx
 Attn: AlaskaCare Benefit Appeals
 P.O. Box 3410
 Lisle, IL 60532-8410

Please call the OptumRx Health Care Advisor phone number on the back on your ID card if you need help completing this form.

ORX991529-181210