CATERPILLAR® PRESCRIPTION DRUG EXPENSE CLAIM FORM

(for prescription drugs purchased **on or before 12/31/2018**)

INSTRUCTIONS

1. Complete the form in entirety.
2. Only one claimant may be submitted per form.
3. Include Copies of Rx receipts (not register receipts)
   Rx receipts should show the following prescription information for each expense.

** Pharmacy Name and Address*	** Patient Name*
**Prescription Number*	** Fill Date*
**Drug Name and Strength*	**Quantity and Days Supply*
**Drug Cost*	**Amount Paid Out of Pocket*

   Your claim will not be processed unless this form and accompanying receipts are complete.
4. Sign and date your claim.

RETURN COMPLETED CLAIM TO:

Fax: 866-713-6511 - or - Mail form to:
OptumRx, Claims Dept.
Attn: Clerks
P.O. Box 29044, Hot Springs, AR 71903

CLAIMANT INFORMATION - (Please Print)

Employee's Name (First Name / Middle Initial / Last Name)		OptumRx Member ID	
Mailing/ Street Address	**City**	**State**	**Zip Code**
Claimant's Name (First Name / Middle Initial / Last Name)		**Claimant's Birthdate**	**Relationship to Employee**
If your medication is covered under ANY OTHER Insurance Plan, provide the name of the Employer and Insurance Company:			

I certify that the above information is correct and that the person is eligible for benefits. I have received the medication described below and authorize release of all information contained on this voucher to OptumRx and the underwriter.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

Employee Signature: _____ **Date** _____

OptumRx Member Service: 844-368-4668
Hours of operation: 24/7

Additional copies of this form available at Benefits.Cat.com

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