OPTUMRx®

AlaskaCare Pharmacy Plans

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 *(mm/dd/yyyy)*	Member's ID number		Plan type O Employee O Retiree
Member's first name	Middle initial *(MI)*	Member's last name	Date of birth *(mm/dd/yyyy)*

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

First name	Middle initial *(MI)*	Member's last name	Date of birth *(mm/dd/yyyy)*
Member's ID number			

Relationship to person requesting the appeal: O Self O Spouse O Child O Other _____

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.**

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 *(Please use additional pages if necessary.)*		

Note: When submitting this form with your request please include:

- ☐ Receipts and/or correspondence for the medication(s)
- ☐ 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.