REIMBURSEMENT FORM FOR OVER-THE-COUNTER ITEMS (OTC)

Please attach a detailed receipt from the pharmacy that include the information requested on this form. **All reimbursements are subject to plan terms and conditions and may be reduced from the submitted amounts based on plan cost and copayments.**

Patient Information	
Member First Name:	Member Last Name:
Member ID#:	Date of Birth:
Member Address:	
City:	State:
Phone Number:	Zip Code:
Reason for Request	
_____ Have not received an OTC Benefit Card	_____System Out-Of-Service. Pharmacy could NOT process the transaction in the corresponding terminal
_____Used a non-participating pharmacy for OTC Benefit services.	_____Other. Please explain:

Please attach itemized receipt for the items or you may ask your pharmacist to complete the remaining information. **See page 2 of this form for more space. We must have this information to process your claim.**

Prescription Information			
Item # 1:			
Item Name	Date of the purchase	Pharmacy Name	Amount Paid
Item # 2:			
Item Name	Date of the purchase	Pharmacy Name	Amount Paid

Confidentiality Notice: This communication is privileged and confidential, and/or protected health information (PHI) or electronic protected health information (ePHI), and may be subject to protection under the law, including HIPAA. This communication is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, be advised that any use, disclosure, distribution, copying, or action taken in reliance on the contents of this communication is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for its return. **H5577_ 15660323_C**

Prescription Information			
Item # 3:			
Item Name	Date of the purchase	Pharmacy Name	Amount Paid
Item # 4:			
Item Name	Date of the purchase	Pharmacy Name	Amount Paid

Special Instructions:

We must be able to clearly read the information on the prescription label receipt You can send the prescription label receipt(s), cash register receipts, and this completed form at any of our MCS Service Center and/or send via mail or fax to:

Mail to: MCS Advantage, Inc.
Pharmacy Department
P.O. Box 191720
San Juan, PR 00919-1720

Fax to: 1-787-620-1340

If you need help completing this form, please call our Customer Service Call Center number on your card.

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_______________________________ _______________________

Signature of Plan Member **Date**

Release of Information: I certify that I have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury. I have indicated in the Coordination of Benefits area above if there is primary prescription drug coverage under another medical plan. I authorize release of all information pertaining to this claim to MCS Classicare; the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

_______________________________ _______________________

Signature of Plan Member **Date**

MCS Classicare is an HMO plan subscribed by MCS Advantage, Inc.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-627-8183. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-627-8183. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-627-8183。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-627-8183。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-627-8183. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-627-8183. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-627-8183 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-627-8183. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

MCS Classicare (HMO)

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-627-8183 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-627-8183. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول بمساعدتك. على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-.3818726668 سيقوم شخص ما يتحدث العربية هذه خدمة مجانية.

Hindi: हमारे ा या दवा की योजना के बारे म आपके िकसी भी पर् के जवाब देने के िलए हमारे पास मु दुभािषया सेवाएँ उपल ह . एक दुभािषया पर्ा करने के िलए, बस हम 1-866-627-8183 पर फोन कर . कोई जो िह ी बोलता है आपकी मदद कर सकता है. यह एक मु सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-627-8183. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-627-8183. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-627-8183. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-627-8183. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-627-8183 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。