Income Related Monthly Adjustment Amount (IRMAA) Enrollment and Reoccurring Health Reimbursement Claim Form

If the member is subject to the Medicare Part D IRMAA surcharge, the Division of Retirement and Benefits will reimburse you for the full amount through tax-advantaged Health Reimbursement Account (HRA). To help avoid claim processing delays, the member must complete this form, sign and date at the bottom, and attach proof of the IRMAA surcharge. For assistance with the form or for questions about the IRMAA HRA Program, **please contact OptumRx at 855-409-6999.**

1 Member Information

Please note: Member is defined as the individual who is being assessed the IRMAA surcharge.

First Name:

Last Name:

OptumRx ID: Enter member ID located on the OptumRx ID card including numbers after the dash (17 numbers total)

__ __ __ __ __ __ __ __ __ __ __ __ ____ - ______

Social Security Number: __ __ __ - __ __ - __ __ __ __

Date of Birth (MM/DD/YY):

Address:

City, State ZIP:

Phone Number:

Email Address:

Please note: The address information provided here will not update the address on file with the Division of Retirement and Benefits. To update the member's address, **please contact the Division at 800-821-2251.**

2 IRMAA Reimbursement Information

This form must be used to request member Medicare Part D IRMAA premium reimbursement. Reoccurring premium requests must be resubmitted each plan year. If you have a change or cancellation in your Medicare Part D IRMAA, please contact OptumRx at 855-409-6999. If the member and member's covered dependent(s) are eligible for Medicare Part D IRMAA premium reimbursement, each request must be submitted separately. If the member was enrolled under the enhanced Employer Group Waiver Program (EGWP) prescription coverage mid year, the "From Date" will be the member's EGWP effective date.

From Date (MM/DD/YYYY):

To/Thru Date (MM/DD/YYYY):

Monthly Amount Requested: $

Number of Months:

Total Amount Requested: $

Please note: To determine the Monthly Amount Requested take the total amount listed on your Social Security determination letter and divide by the number of months you are eligible for Medicare Part D or use the amount deducted from your monthly Social Security disbursement.

3 Required Documentation

Please provide copies of one of the acceptable documents listed below which show proof of the IRMAA surcharges that are eligible for reimbursement. If we are unable to read the documents due to the quality of the copy, we may need to request additional information.

- Determination Letter from the Social Security Administration
- Medicare Bill

4 Agreement and Member Signature

I certify that I have incurred the expense on this form. These expenses are for eligible premiums. I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. Upon receiving notice of a charge in premium or a cancellation of coverage, I will notify OptumRx immediately at 855-409-6999. I have received and read the printed materials for the plan. I agree to all the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

✗ ____________________ ________________

Member's Signature **Date**

Where to return your form and documentation?

By mail: OptumRx, Attn.: AlaskaCare IRMAA, P.O. Box 2135, Mission, KS 66201

By email: AlaskaCare_IRMAA@optum.com

By fax: 1-844-271-6714

Financial Sanctions Exclusions (Anti-Money Laundering - AML)- Optum cannot and shall not provide any payment or service in violation of any United States (US) economic or trade sanctions.

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