



MEDICAID PRESCRIPTION CLAIM REIMBURSEMENT FORM

For claim reimbursement, complete this form and mail to:

Pharmacy Services Member Reimbursements
P.O. Box 989000
West Sacramento, CA 95798

Incomplete forms will delay processing. Pharmacy Customer Service can be reached at (800) 460-8988.

Important!

- It is our intent to process the claims within 60 days
- Keep a copy of all documents submitted for your records
- Reimbursement is not guaranteed; claims are subject to plan limitations, exclusions and provisions
- Claims must be submitted for reimbursement within 1 year of purchase

To be completed by insured. Please PRINT clearly

I. MEMBER AND PRESCRIPTION PLAN INFORMATION	
Member Name:	Member ID #:
Address:	Phone:
City, State, Zip Code:	Group #:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date: ___/___/___
Plan Name:	
Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other: _____	
Coordination of Benefits (COB) Is the medicine covered under any other group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No *If other coverage is Primary, include the Explanation of Benefits (EOB) with this form.	
Explanation for the request	



II. PRESCRIPTION INFORMATION

This section must be completed by you or your dispensing pharmacist. One prescription label should be attached for each prescription.
Also, include a copy of your pharmacy receipt with this form.

Pharmacy Name:	Pharmacy Address:	
RX Number:	Date Filled: ___/___/_____	Quantity:
RX Name & Strength:	Days Supply (30, 60, 90):	NDC #: _____-_____-_____
Dr. Name:	Price/Amount Paid:	Comments:
Pharmacy Name:	Pharmacy Address:	
RX Number:	Date Filled: ___/___/_____	Quantity:
RX Name & Strength:	Days Supply (30, 60, 90):	NDC #: _____-_____-_____
Dr. Name:	Price:	Comments:

Important! A signature is required.

Please sign and date here: I certify that the above information is correct and the prescriptions listed above are for myself or eligible members of my family who have received the medication described above, and I authorize release of all information contained on this claim form to Pharmacy Services and my plan sponsor.

Signature: _____ Date signed: _____