Prescription Claim Reimbursement Form

For claim reimbursement, complete and mail this form to:
Centene Pharmacy Services, 7625 N Palm Ave, Suite 107 Fresno, CA. 93711. Forms can also be faxed to (844) 678-5767 or email to claimsprocessing@centene.com. **Incomplete forms will delay processing.** Pharmacy Services' customer service desk can be reached at **855-580-1688**.

Important!

- It is our intent to process the claims within 30 days
- Keep a copy of all documents submitted for your records
- Reimbursement is not guaranteed; the claims are subject to limitations, exclusions and provisions of the Plan
- **Claims must be submitted for reimbursement within 1 year of purchase**

To be completed by insured. Please PRINT clearly.

1. MEMBER INFORMATION	
Member Name:	Date of Birth:
Address (street/city/state) :	Phone # :

2. PRESCRIPTION PLAN INFORMATION	
Insured's Member ID # :	Group # :
Employer:	

3. PATIENT INFORMATION
Relationship to insured: ○ Self ○ Spouse ○ Dependent ○ Other
Coordination of Benefits (COB): Is the medicine covered under any other group insurance? ○ Yes ○ No **If other coverage is Primary, include the Explanation of Benefits (EOB) with this form.*
Explanation for the request:

(Continued on the back)

4. PRESCRIPTION INFORMATION		
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 #:	DAW:	Price:
Comments:		
Pharmacy Name:		
Pharmacy Address:		
RX Number:	Date Filled: / /	Quantity:
RX Name & Strength:		Days Supply (30, 60, 90):
NDC #:	DAW:	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 Centene Pharmacy Services and my plan sponsor.

Signature: ______________________________ Date signed: ______________