



PRESCRIPTION CLAIM REIMBURSEMENT FORM

For claim reimbursement, complete and mail to:

Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720

Forms may also be faxed to (844) 678-5767. **Incomplete forms will delay processing.**

The Pharmacy Services customer service desk can be reached at (800) 413-7721

To be completed by insured. Please PRINT clearly

I. Member Information		II. Prescription Plan Information	
Member Name:		Insured's Member ID Number:	
Address:		Group Number:	
Birth Date:	Phone:	Employer:	
III. Patient Information			
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other: _____			
Is patient covered by any other medical benefit plan, group policy repayment plan, Medicare, or other government plans? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, give the name of the person carrying coverage: _____			
If yes, name of the alternate coverage (group name, employer, association, etc): _____			
Patient illness or injury (if injury, include a description of the accident, including date and place). _____			
Did condition result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date you last worked prior to treatment for which claim was made: _____			
IV. Prescription Information			
<i>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.</i>			
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 #:	Price:	Price:	Comments:

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: _____