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.
For Question or assistance filling out this form, please contact our Pharmacy Customer Service team at (800) 460-8988.

Important!

- Processing of claims my take up to 30 days
- Keep a copy of all documents submitted for your records
- Reimbursement is not guaranteed; claims are subject to plan limitations, exclusions and provisions

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 #:
Birth Date: ___/___ /_____	Plan Name:

Coordination of Benefits (COB)
Is the medicine covered under any other group insurance? ☐ Yes ☐ No

Explanation for the request.

II. PRESCRIPTION INFORMATION

Please provide information for each prescription.

Prescription 1		
Pharmacy Name:	Pharmacy Address:	
RX Number:	Date Filled: ___ /____ /_____	Quantity:
RX Name & Strength:	Days' Supply (30, 60, 90):	NDC #:
Dr. Name:	Price/Amount Paid:	Comments:

Prescription 2		
Pharmacy Name:	Pharmacy Address:	
RX Number:	Date Filled: ___ /____ /_____	Quantity:
RX Name & Strength:	Days' Supply (30, 60, 90):	NDC #:
Dr. Name:	Price/Amount Paid:	Comments:

Prescription 3		
Pharmacy Name:	Pharmacy Address:	
RX Number:	Date Filled: ___ /____ /_____	Quantity:
RX Name & Strength:	Days' Supply (30, 60, 90):	NDC #:
Dr. Name:	Price/Amount Paid:	Comments:

III. RECEIPTS

You must include a copy of your pharmacy receipt with the completed form.

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:**_____