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!

- Claims will be processed within 60 days
- Keep a copy of all documents for yourself
- Reimbursement is not guaranteed; claims are subject to plan limits and other terms

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: ☐ M ☐ F	Birth Date:___/___/_____	Plan Name:
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.		

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Explanation for the request.

(Continued on the back)

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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:** _____

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