

# Prescription Claim Reimbursement Form

For claim reimbursement, complete and mail this form to 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](mailto:claimsprocessing@centene.com). **Incomplete forms will delay processing.** Pharmacy Services' customer service desk can be reached at (800) 413-7721.

**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

**To be completed by insured. Please PRINT clearly.**

<b>I. MEMBER INFORMATION</b>		<b>II. PRESCRIPTION PLAN INFORMATION</b>
Member Name:		Insured's Member ID #:
Address:		Group #:
Birth Date: ___/___/___	Phone:	Employer:
<b>III. PATIENT INFORMATION</b>		
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.		

#### IV. 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 Pharmacy Services and my plan sponsor.**

Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_