

# 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!

- It is our intent to process the claims within 60 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 #:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date: __/__/____
Plan Name:	
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.	

## 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:** \_\_\_\_\_