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. **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.

<table>
<tr><th colspan="2">I. MEMBER INFORMATION</th><th>II. PRESCRIPTION PLAN INFORMATION</th></tr>
<tr><td colspan="2">Member Name:</td><td>Insured's Member ID #:</td></tr>
<tr><td colspan="2">Address:</td><td>Group #:</td></tr>
<tr><td>Birth Date:___/___/_____</td><td>Phone:</td><td>Employer:</td></tr>
<tr><td colspan="3">III. PATIENT INFORMATION</td></tr>
<tr><td colspan="3">Relationship to insured:
❑Self ❑Spouse ❑Dependent ❑Other_____</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="3">Explanation for the request.</td></tr>
</table>

(Continued on the back)

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:** _____