Prescription Drug *Claim Form*

This claim form is to be used for reimbursement on covered medications provided by pharmacies. The filing of this form does not guarantee reimbursement. Please consult your plan documents for additional coverage information. If you have any questions regarding this form, or require additional forms, please contact Health Net of California, Inc. or Health Net Life Insurance Company (Health Net) at the telephone number listed on your member ID card, or visit **www.healthnet.com.**

Instructions

1. Complete the subscriber/enrollee information section below. You'll find your subscriber ID and group numbers on your Health Net ID card or on the copy of your application that serves as your temporary ID.
2. Please have your pharmacist complete the section on the back, and submit an itemized pharmacy receipt that includes the same information.
3. You must complete a separate claim form for each family member. You also need a separate form for each pharmacy you use.
4. This form must be completed in full, or it will be returned for completion. Please allow four weeks for completed claim forms to be processed.
5. Return the completed form to:
   Health Net of California
   C/O Caremark
   PO Box 52136
   Phoenix, AZ 85072-2136

Subscriber/Enrollee

Subscriber/Enrollee ID #:	Group #:	Contact phone #:	
Subscriber/Enrollee last name:	First name:		MI:
Address:	City:	State:	ZIP:
Patient name:	Prescriptions were for (diagnosis):	Patient's gender:	Date of birth:

Is this medication for an on-the-job-injury? ☐ Yes ☐ No

Is this medication covered under any other group insurance plan? ☐ Yes ☐ No

If "Yes," give name of insurance company and other employer: _____

Health Net PPO, Flex Net and Medicare Supplement are fully underwritten by Health Net Life Insurance Company.

HealthNet HMO is offered by Health Net of California, Inc. Health Net of California, Inc. is a subsidiary of Health Net, Inc.

I certify that the above information is correct and that the above-written person is eligible for benefits. I have received the medication described herein and authorize release of all information contained on this voucher to Health Net or its agent.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempting assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

X _____ _____

Signature (insured person) Date

(continued)

Please ask your pharmacist to complete the remaining portion. We cannot process this form without this information.

Rx number: 1.	Date filled:	Check one: ☐ New ☐ Rx refill ☐ Compound	Quantity:	Rx directions:	Days supply:	Rx price incl tax:
Medication name and strength:				MD DEA number:	NDC number required:	
Rx number: 2.	Date filled:	Check one: ☐ New ☐ Rx refill ☐ Compound	Quantity:	Rx directions:	Days supply:	Rx price incl tax:
Medication name and strength:				MD DEA number:	NDC number required:	
Rx number: 3.	Date filled:	Check one: ☐ New ☐ Rx refill ☐ Compound	Quantity:	Rx directions:	Days supply:	Rx price incl tax:
Medication name and strength:				MD DEA number:	NDC number required:	

If compound – please fill out the information below.

Place pharmacy label here.

Pharmacy name_____

Street address_____

City_____ State_____ ZIP_____

7-digit NABP number required _____

(Please obtain this number from your pharmacy.)

Are you a Health Net participating pharmacy? ☐ Yes ☐ No

Pharmacist signature X _____

Note: Benefits are payable directly to the covered individual, and any assignment of these benefits is void.

Compound prescription information

☐ Include Rx number(s), drug name(s), strength(s), and date filled.

☐ Include all the NDC number(s) for the drug(s) dispensed.

☐ Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments, and injectables.

Compound prescriptions

Rx number	NDC number	Drug ingredient	Quantity	Cost