buckeye health plan™
A Medicaid Plan

Prescription Claim Reimbursement Form

For claim reimbursement, complete and mail this form to Pharmacy Services, 5 River Park Place East, Suite 210, Fresno, CA 93720. Forms can also be faxed to (844) 678-5767. **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.

I. MEMBER INFORMATION		II. PRESCRIPTION PLAN INFORMATION
Member Name:		Insured's Member ID #:
Address:		Group #:
Birth Date:___/___/_____	Phone:	Employer:

III. PATIENT INFORMATION

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.

Explanation for the request.

(Continued on the back)

IV. 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 #:	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:** _____