Health Net®

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.

INSTRUCTIONS

1. Complete the subscriber 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 lower section,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. When complete, fold and seal the form, affix postage, and mail it. If you have any questions regarding this form, or require additional forms, please contact Health Net at the telephone number listed on your member ID card or visit www.healthnet.com.

SUBSCRIBER

SUBSCRIBER ID#	GROUP#	CONTACT PHONE #	
SUBSCRIBER LAST NAME	FIRST NAME	MI	
ADDRESS	CITY	STATE	ZIP

PATIENT NAME	PRESCRIPTIONS WERE FOR (Diagnosis)	PATIENT 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: _____

PPO (OPTIONS), Health Net National PPO, Flex-Net and Medicare Supplement are fully underwritten by Health Net Life Insurance Company.

I certify that the above information is correct and that the above-checked 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 represesnt 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

PLEASE ASK YOUR PHARMACIST TO COMPLETE THE REMAINING PORTION. WE CANNOT PROCESS THIS FORM WITHOUT THIS INFORMATION.

Rx NUMBER	DATE FILLED	CHECK ONE	QUANTITY	Rx DIRECTIONS	DAYS SUPPLY	Rx PRICE INCL TAX
1.		❑ NEW Rx ❑ REFILL ❑ COMPOUND				
MEDICATION NAME AND STRENGTH		MD DEA NUMBER			NDC NUMBER REQUIRED	
Rx NUMBER	DATE FILLED	CHECK ONE	QUANTITY	Rx DIRECTIONS	DAYS SUPPLY	Rx PRICE INCL TAX
2.		❑ NEW Rx ❑ REFILL ❑ COMPOUND				
MEDICATION NAME AND STRENGTH		MD DEA NUMBER			NDC NUMBER REQUIRED	
Rx NUMBER	DATE FILLED	CHECK ONE	QUANTITY	Rx DIRECTIONS	DAYS SUPPLY	Rx PRICE INCL TAX
3.		❑ NEW Rx ❑ REFILL ❑ COMPOUND				
MEDICATION NAME AND STRENGTH		MD DEA NUMBER			NDC NUMBER REQUIRED	

IF COMPOUND – PLEASE FILL OUT THE INFORMATION ON THE REVERSE SIDE

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.

RETURN COMPLETED FORM TO THE ADDRESS SHOWN ON THE REVERSE SIDE.

Postage Required
Post Office will not deliver without proper postage.

HEALTH NET OF CALIFORNIA
C/O Caremark
PO Box 52136
Phoenix, AZ 85072-2136

COMPOUND PRESCRIPTION INFORMATION

- ❑ Include Rx number(s), drug name(s), strength(s), and date filled.
- ❑ Include NDC number(s) for the drug(s) dispensed.
- ❑ Enter the NDC number of the most expensive ingredient of the legend drug used.
- ❑ 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