PRESCRIPTION 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. *Additional forms are available at your place of employment, or from Health Net. If you have any questions regarding this form, or require additional forms, please contact Health Net at the telephone number listed on your Identification Card.*

SUBSCRIBER INFORMATION

PRODUCT		SUBSCRIBER ID#	GROUP#
SUBSCRIBER LAST NAME	FIRST NAME	MI	
ADDRESS	CITY	STATE	ZIP
PATIENT NAME	PRESCRIPTIONS WERE FOR	PATIENT SEX	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 represent that there has been no assignment of benefits hereunder.

Signature required or rejection will occur.

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 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 ❑ OMPOUND	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 ON THE REVERSE SIDE

PLACE PHARMACY LABEL HERE

PHARMACY NAME ______________________

STREET ADDRESS ______________________

CITY ____________ STATE _______ ZIP ________

7-DIGIT NABP NUMBER REQUIRED ____ ____ ____ ____ ____ ____ ____
(PLEASE OBTAIN THIS FROM YOUR PHARMACY)

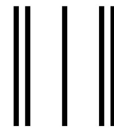
ARE YOU A HEALTH NET PARTICIPATING PHARMACY? ❑ YES ❑ NO

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.

10882 (10/01)



Proper Postage Required for Delivery

HEALTH NET OF CALIFORNIA
C/O ADVANCEPCS INC
P O BOX 853901
RICHARDSON TX 75085-3901

MOISTEN AND SEAL-DO NOT STAPLE

MOISTEN AND SEAL-DO NOT STAPLE

C O M P O U N D P R E S C R I P T I O N I N F O R M A T I O N

- ❑ 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.

C O M P O U N D P R E S C R I P T I O N S

For pharmacy use only

Rx Number	NDC Number	Drug Ingredient	Quantity