

HEALTH NET MEDICARE PRESCRIPTION CLAIM FORM



This claim form is to be used to request reimbursement for covered Medicare Part D medications. Please consult your Evidence of Coverage for coverage information.

INSTRUCTIONS:		
1. Complete the member information section below. You'll find your Health Net member ID and group numbers on your Health Net Medicare ID card or on the copy of your application that serves as your temporary ID. 2. This form must be completed in full or it will be returned for completion. 3. When complete, please mail with itemized pharmacy receipt(s) (cash register receipts will not be accepted) to the pharmacy claims address on the back of this form. <i>Additional forms are available from Health Net. Please call the Customer Service number on your member ID Card. Or you can print a copy of the form from our website www.healthnet.com.</i>		
MEMBER INFORMATION:		
Member ID#:	Group#:	
Member Name (Last, First):		
Address:		
City:	State:	ZIP Code:
Patient Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: (____ / ____ / _____)	
Has your claim been processed with another insurance carrier? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach a copy of your Explanation of Benefits (EOB) or statement from the other coverage and/or your receipt from the pharmacy, and provide the information requested below.		
Name of Insured Policyholder:	Name of Insured's Employer:	
Name of Other Insurance Company:	Policy Number (Other Insurance Company):	
Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family		
I certify that the above information is correct and that the above- person is eligible for benefits. I have received the medication described herein and authorize release of all information contained on this form to Health Net or its agent. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignments or attempting assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder. Signature is required or rejection will occur.		
X _____ Signature (Insured Person)		_____ Date

Staple Receipt(s)/Label(s) Here:

OPTIONAL Pharmacy Information:
Please ask your pharmacist for assistance in completing the remaining portion

Rx Number:	Date Filled:	Check one:	
1.		<input type="checkbox"/> New Rx <input type="checkbox"/> Refill <input type="checkbox"/> Compound	
2.		<input type="checkbox"/> New Rx <input type="checkbox"/> Refill <input type="checkbox"/> Compound	
Quantity:	Rx Directions:	Days Supply:	Rx Price incl. Tax:
1.			
2.			
Medication Name and Strength		MD DEA Number	NDC Number
1.			
2.			
Pharmacy Name:			
Street Address:			
City:		State:	Zip:
7-Digit NABP Number: _ _ _ _ _		Are you a Health Net participating pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
X _____		_____	
Pharmacist's Signature (Optional)		Date	

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

CLAIM SUBMISSION INSTRUCTIONS:

Please mail claim form and pharmacy receipt(s) to:

Orange (PDP - All Regions) or Pearl (PFFS - All Regions): Health Net Attn: Claims 10540 White Rock Rd., Ste. 280 Rancho Cordova, CA 95670	Amber, Ruby, Sage, Violet or CoCare (AZ): Health Net of Arizona Attn: Pharmacy Department 950 N. Finance Center Drive Tucson, AZ 85710	
Amber, Ruby or Violet (CA): Health Net of California Attn: Pharmacy P.O. Box 9103 Van Nuys, CA 91409-9103	Amber, Navy, Ruby or Sage (CT): Health Net of the Northeast Attn: Pharmacy Mgmt - Medicare Part D P.O. Box 904 Shelton, CT 06484-9831	Violet or Sage(OR): Health Net Pharmacy Claims Department 13221 SW 68th Parkway Tigard, OR 97223