



# For University of California members transitioning from PacifiCare — 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

- 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.
- Please complete the lower section, and submit an itemized pharmacy receipt that includes the same information.
- You must complete a separate claim form for each family member. You also need a separate form for each pharmacy you use.
- 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.
- 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](http://www.healthnet.com).

## SUBSCRIBER INFORMATION

PRODUCT (HMO, SELECT, FLEXNET, ELECT Open Access, MED SUPP)		SUBSCRIBER ID#		GROUP#
SUBSCRIBER LAST NAME		FIRST NAME		MI
ADDRESS		CITY		STATE ZIP
PATIENT NAME	PRESCRIPTIONS WERE FOR <i>Incorrect copy charged</i>		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 \_\_\_\_\_ DATE \_\_\_\_\_  
 SIGNATURE (INSURED PERSON)

## PLEASE COMPLETE THE REMAINING PORTION

Rx NUMBER	DATE FILLED	CHECK ONE	QUANTITY	Rx DIRECTIONS	DAYS SUPPLY	Rx PRICE INCL TAX
1.		<input type="checkbox"/> NEW Rx <input type="checkbox"/> REFILL <input type="checkbox"/> COMPOUND				
MEDICATION NAME AND STRENGTH		MD DEA NUMBER		NDC NUMBER REQUIRED		
2.		<input type="checkbox"/> NEW Rx <input type="checkbox"/> REFILL <input type="checkbox"/> COMPOUND				
MEDICATION NAME AND STRENGTH		MD DEA NUMBER		NDC NUMBER REQUIRED		
3.		<input type="checkbox"/> NEW Rx <input type="checkbox"/> REFILL <input type="checkbox"/> 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	<b>7-DIGIT NABP NUMBER REQUIRED</b> _____ (PLEASE OBTAIN THIS FROM YOUR PHARMACY)
PHARMACY NAME _____	ARE YOU A HEALTH NET PARTICIPATING PHARMACY? <input type="checkbox"/> YES <input type="checkbox"/> NO
STREET ADDRESS _____	PHARMACIST SIGNATURE X _____
CITY _____ STATE _____ ZIP _____	<b>NOTE: BENEFITS ARE PAYABLE DIRECTLY TO THE COVERED INDIVIDUAL, AND ANY ASSIGNMENT OF THESE BENEFITS IS VOID.</b>

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Proper  
Postage  
Required  
for Delivery

**HEALTH NET OF CALIFORNIA**  
ATTN: PHARMACY  
PO BOX 9103  
VAN NUYS, CA 91409-9103

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**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.

<b>COMPOUND PRESCRIPTIONS</b>			
<b>COMPOUND PRESCRIPTIONS</b>			
Rx Number	NDC Number	Drug Ingredient	Quantity