YouthCare
HealthChoice Illinois

Prescription Claim Reimbursement Form

For claim reimbursement, complete and mail this form to:
Centene Pharmacy Services, 7625 N Palm Ave, Suite 107 Fresno, CA. 93711. Forms can also be faxed to (844) 678-5767 or email to claimsprocessing@centene.com. **Incomplete forms will delay processing.** Pharmacy Services' customer service desk can be reached at **877-236-0904**.

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
- Claims must be submitted for reimbursement within 1 year of purchase

To be completed by insured. Please PRINT clearly.

1. MEMBER INFORMATION	
Member Name:	Date of Birth:
Address (street/city/state) :	Phone #:

2. PRESCRIPTION PLAN INFORMATION	
Insured's Member ID #:	Group #:
Employer:	

3. 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*)

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4. PRESCRIPTION INFORMATION		
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 Centene Pharmacy Services and my plan sponsor.

Signature:_____ Date signed:_____