PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

4665 Business Center Drive
Fairfield, California 94534

PRESCRIPTION REIMBURSEMENT REQUEST

Complete sections A through C. Attach proof of payment and pharmacy receipt(s). Print clearly.

The pharmacy receipt(s) are given to you with the medication warnings. They are not the receipt from the cash register.

Mail the completed form and pharmacy receipt(s) in the enclosed postage paid envelope or fax them to (707) 863-4415, Attention: EUnit or mail it to us at:

Partnership HealthPlan of California
Attention: Enrollment Unit
4665 Business Center Lane
Fairfield, CA 94534

Need help? Call us at (800) 863-4155. We are available Monday through Friday from 8 a.m. to 5 p.m. TTY users should call the California Relay Service at (800) 735-2929 or call 711.

Section A- Who were the medications for?

Member Name: ______________________ Phone #: ______________________

PHC ID #: ______________________ DOB: ______________________

Section B- Reimbursement Information:

Total number of prescription(s) you are submitting: __________ Total amount requesting: $ __________

If approved, who do we make the check out to? ______________________________

Where do we mail the check? ______________________________

Section C- Why did you pay for the prescription(s)?

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SAMPLE RECEIPT

Anytime Pharmacy #1234
123 Any Street
Home Town, US 12345-6789

(509)555-1234
Store NPI: 1234567890

RX:1234567

Date Filled: 1/1/2000

DOR: JANR
DOB: 01/01/1900
456 Home Road
Home Town, US 12345

(509) 555-5678

Amoxicillin 500 mg capsule (Tera)
00000 1111 22 QTY: 45
NDC: 456790123

DAW: 0
Days Supply: 30

A. SMITH, MD NPI# 10210
U&C: 200.00

PAY: 20.00

PHC USE ONLY

Make check out to: **( ) Approved** **( ) Denied**

Mail to: 4665 Business Center Dr. Fairfield CA 94534 **( ) Force to pay**

Amount approved for payment: $______________

Authorized Signature **Date:**

MEDIMPACT Use Only

Completed by: **Date:**