



## PRESCRIPTION CLAIM FORM

This claim form is to be used for reimbursement on covered medications provided by participating pharmacies. 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 have your pharmacist 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. *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 - PLAN TYPE MUST BE CHECKED

PLAN TYPE <input type="checkbox"/> HMO <input type="checkbox"/> Flex Net <input type="checkbox"/> OPTIONS (PPO) <input type="checkbox"/> Seniority Plus <input type="checkbox"/> Individual <input type="checkbox"/> SELECT (POS) <input type="checkbox"/> ELECT (POS)				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. \_\_\_\_\_

SELECT and ELECT consist of HMO services provided by Health Net and insurance benefits underwritten by Health Net Life Insurance Company. OPTIONS and Flex-Net are fully underwritten by Health Net Life Insurance Company. Health Net National PPO is underwritten by Lincoln National.

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 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.		<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  
 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.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Proper  
Postage  
Required  
for Delivery

SAP 8670 (9/99)

**HEALTH NET**  
C/O ADVANCE PARADIGM INC  
P O BOX 853901  
RICHARDSON TX 75085-3901



-----  
MOISTEN AND SEAL-DO NOT STAPLE

-----  
MOISTEN AND SEAL-DO NOT STAPLE

**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.

**COMPOUND PRESCRIPTIONS**

For pharmacy use only

Rx Number	NDC Number	Drug Ingredient	Quantity