



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

1. 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.
2. Please have your pharmacist complete the lower section, and submit an itemized pharmacy receipt that includes the same information.
3. You must complete a separate claim form for each family member. You also need a separate form for each pharmacy you use.
4. 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.
5. 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.

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 (Diagnosis) | | 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 _____
 SIGNATURE (INSURED PERSON)

 DATE

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.



Postage
Required
Post Office will
not deliver
without proper
postage.

|||||
HEALTH NET OF CALIFORNIA
C/O CAREMARK
PO BOX 52136
PHOENIX AZ 85072-2136



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 | | | |
|-------------------------------|------------|-----------------|----------|
| Rx Number | NDC Number | Drug Ingredient | Quantity |
| | | | |
| | | | |
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