meridian

300 S. Riverside Plaza, Suite 500
Chicago, IL 60606

866-606-3700 (TTY 711)
ILmeridian.com

MEDICAID PRESCRIPTION CLAIM REIMBURSEMENT FORM

For claim reimbursement, complete this form and mail it to:
Pharmacy Claims Department
P.O. Box 989000
West Sacramento, CA 95798

Incomplete forms will delay processing. Envolve Pharmacy Solutions Customer Service can be reached at **800-460-8988,** TTY users should call **711.**

Important!

- It is our goal to process claims within 60 days
- Keep a copy of all documents submitted for your records
- Reimbursement is not guaranteed. Claims are subject to plan limitations, exclusions, and provisions.

TO BE COMPLETED BY THE INSURED. PLEASE PRINT CLEARLY.

I. MEMBER AND PRESCRIPTION PLAN INFORMATION		
Member Name:		**Member ID Number:**
Address:		**Phone:**
City, State, Zip Code:		**Group Number:**
Gender: M F	**Birth Date:____/____/_____**	**Plan Name:**
Relationship to Insured: **Self Spouse Dependent Other:**		
Coordination of Benefits (COB) Is the medicine covered under any other insurance? Yes No *If your other coverage is Primary, include the Explanation of Benefits (EOB) with this form.		
***Explanation for the request**		

meridian

II. PRESCRIPTION INFORMATION		
This section must be completed by the member or the dispensing pharmacist. One prescription label must be attached for each prescription. Please include a copy of your pharmacy receipt with this form.		
Pharmacy Name:	**Pharmacy Address:**	
Rx Number:	**Date Filled:___/____/_____**	**Quantity:**
Rx Name and Strength:	**Days' Supply (30, 60, 90):**	**NDC Number:** _____-_____-_____
Provider Name:	**Price/Amount Paid:**	**Comments:**
Pharmacy Name:	**Pharmacy Address:**	
RX Number:	**Date Filled: __ /___/_____**	**Quantity:**
RX Name & Strength:	**Days' Supply (30, 60, 90):**	**NDC Number:** _____-_____-_____
Provider Name:	**Price:**	**Comments:**

Important! A signature is required.
Please sign and date here.

I certify that this information is correct. The drugs listed are for eligible family members or me. I received the medication listed. I authorize the release of all information on this claim form to Centene Management Company and the plan sponsor.

Signature:
_____

Date signed: _____