MOLINA HEALTHCARE

Forward claim form with original receipt(s) to:
Molina Healthcare
Pharmacy Services
880 West Long Lake Road, Suite 600
Troy, Michigan 48098

IMPORTANT: See Instructions below

PRESCRIPTION DRUG REIMBURSEMENT FORM

PATIENT INFORMATION:

Patient Name (Last) _____ Patient Name (First) _____ M.I. _____

Patient I.D. Number _____ Date of Birth (mm/dd/yyyy) _____

Street Address _____

City _____ State _____ ZIP _____

Daytime Telephone Number _____

BENEFIT COVERAGE

IMPORTANT: I certify that the Member information entered on this form is correct, that Member named is eligible for the benefits, and that I have received the medications described. I also authorize release of all information pertaining to this claim to the plan administrator.

Please choose one**:**

Medicaid _____ Marketplace (Health Insurance Exchange) _____

Member/Authorized Representative _____ D a t e _____

PHARMACIST OR MEMBER MUST COMPLETE THIS SECTION FOR EACH RX:

Prescription Number _____ Date Rx Filled _____ Quantity _____

Prescriber's Name _____ Drug Name and Strength _____

Total Amount Paid _____

Prescription Number _____ Date Rx Filled _____ Quantity _____

Prescriber's Name _____ Drug Name and Strength _____

Total Amount Paid _____

PHARMACY INFORMATION:

Pharmacy Name _____ Pharmacy Address _____

City _____ State _____ Zip _____

Pharmacy Phone _____ Pharmacy NPI _____ Pharmacist Signature _____

INSTRUCTIONS

Please read carefully before completing this form. Payment will be delayed unless all information is completed by the Member or Pharmacist. Claims should be filed within 1 year. Molina strongly advises that Members make copies of completed forms and receipts for their records.

WHEN SHOULD THESE REIMBURSEMENT FORMS BE USED?

Whenever your Member ID card is unavailable
When your insurance is not accepted by a participating pharmacy
Other situations where you are due a reimbursement from Molina Healthcare

MEMBER & BENEFIT COVERAGE INFORMATION

Please fill out all of the member information on the top portion of the form and sign and date the form.
The Pharmacy may be able to help you with sections numbered 1 and 2 with all of the prescription information.
Please limit the number of prescriptions to two per form.

MAIL THE REIMBURSEMENT FORM AND ADDITIONAL PRESCRIPTION INFORMATION TO:

Molina Healthcare
Pharmacy Services
880 West Long Lake Road, Suite 600
Troy, Michigan 48098

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

59A-16C-8 NMSA (Insurance Fraud Act)

PLEASE TAPE (DO NOT STAPLE) THE ORIGINAL DETAILED PRESCRIPTION RECEIPT(S) BELOW TO ENSURE RECEIPT(S) ARE NOT LOST.

(PHOTOCOPIES AND CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE)