Prescription Claim Form

Cardholder Name (Last, First, MI)

Date of Birth **Cardholder ID Number**

Cardholder's Home Address

City **State** **Zip Code** **Daytime Phone Number**

Cardholder's Signature and Date

I certify that all the information provided is correct and that the prescriptions submitted are for myself as an eligible member. I certify that I have received this medication(s) and I authorize release of all information contained on this claim to PerformRx.

Number of Prescriptions **Total Amount Spent**

Total #_____________ $_________________

If CCHP approves reimbursement, it will be for the contracted amount that CCHP would have paid to PerformRx. This amount may be less than the 'Total Amount Spent' by the member.

Reason For the Request (Please be specific)

Prescription Information:

Important: All prescription claims must have prescription receipt labels, which include:

Pharmacy Name/Address-Date Filled- Drug Name, Strength, and NDC# - Rx Number- Quantity Price – Days Supply – Cardholder's Name

Claims received missing any of the above information may be returned of payment may be denied or delayed.

Please read the following instructions carefully and complete form on the reverse side.

Cardholder's Information

1. Print Cardholder's Name (Last, First, Middle Initial)
2. Print Cardholder's date of birth
3. Print the Cardholder's ID number (located on the Cardholder's ID card)
4. Print the Cardholder's address and telephone number

Important: Claim must be signed.

Unsigned claim forms cannot be processed and will be returned.

Patient Information

1. Indicate the number of prescriptions attached.
2. Provide the total amount of the request.
3. Provide written reason for your request for reimbursement,

Prescription Information

- Pharmacy name and address
- Date filled
- Drug name, strength, and NDC number

- Rx Number
- Quantity
- Days supply
- Price
- Member's Name

(Please note that requests missing any of the following information may be returned or payment may be denied)

Reason for Request

This section is used to explain the reason for the reimbursement request.

Please return this claim to: Contra Costa Health Plan

P.O. Box 496

Essington, PA 19029