PRESCRIPTION CLAIM REIMBURSEMENT FORM

For claim reimbursement, complete and mail to:
Envolve Pharmacy Solutions | 5 River Park Place East, Suite 210 | Fresno, CA 93720
Forms may also be faxed to (844) 678-5767. **Incomplete forms will delay processing.**
Envolve Pharmacy Solutions' customer service desk can be reached at (800) 413-7721

To be completed by insured. Please PRINT clearly

I. Member Information		**II. Prescription Plan Information**
Member Name:		Insured's Member ID Number:
Address:		Group Number:
Birth Date:	Phone:	Employer:

III. Patient Information

Relationship to insured: ❑Self ❑Spouse ❑Dependent ❑Other:_____

Is patient covered by any other medical benefit plan, group policy repayment plan, Medicare, or other government plans?
❑Yes ❑No

If yes, give the name of the person carrying coverage: _____

If yes, name of the alternate coverage (group name, employer, association, etc): _____

Patient illness or injury (if injury, include a description of the accident, including date and place).

Did condition result from employment?
❑ Yes ❑ No If yes, date you last worked prior to treatment for which claim was made: _____

IV. Prescription Information

This section must be completed by you or your dispensing pharmacist. One prescription label should be attached for each prescription. Also, include a copy of your pharmacy receipt with this form.

Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled:	Quantity:
RX Name & Strength:		Days Supply (30,60,90):	
NDC #:	DAW:	Price:	Comments:
Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled:	Quantity:
RX Name & Strength:		Days Supply (30,60,90):	
NDC #:	Price:	Price:	Comments:

Please sign and date here: I certify that the above information is correct and the prescriptions listed above are for myself or eligible members of my family who have received the medication described above, and I authorize release of all information contained on this claim form to Envolve Pharmacy Solutions and my plan sponsor.

Signature: _____ Date signed:_____