PerformRx
The Next Generation PBM

CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

Prescription Claim Form

Cardholder Name (Last, First, M)

Date of Birth | **Gender (M or F)** | **Cardholder ID Number**

Cardholders Home Address

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

Cardholders 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 – Cardholders Name
Claims received missing any of the above information may be returned or payment may be denied or delayed.
Please attach receipts to the receipts to this Prescription Reimbursement Request Form.
Patient printouts from the pharmacy are also acceptable but MUST be signed by the Pharmacist
Cash Register receipts are NOT acceptable for any prescriptions reimbursement request.

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

Cardholder's Information

1. Print Cardholder's Name (Last, First, Middle initial)
2. Print Cardholder's date of birth
3. Select correct letter to indicate the Cardholder's gender (M-male, F-female)
4. Print the Cardholder's ID number (located on the Cardholder's ID card)
5. Print 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

Prescription receipts/labels or patient history printout from the pharmacy, **signed** by the dispensing pharmacist, which includes all information listed below:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Rx Number
- Quantity
- Days supply
- Price
- Member's Name

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

Reason for Request

This section is to be 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