

Prescription Drug Claim Form

In order to process your claim(s), please print and provide ALL information requested below in sections 1 and 2, and **submit** the completed form with the **original pharmacy prescription label/receipt(s)** to:

Central Health Medicare Plan ATTN: CLAIMS 1540 Bridgegate Drive, Diamond Bar, CA 91765

Please check which plan you are currently enrolled in:

Central Health Medicare Plan (001)
 Central Health Medi-Medi Plan (002)
 Central Health Value Plan (003)

Section 1 – Primary Member/Cardholder Information			
Member ID Number:		Date of Birth:	
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.	Last Name:	First Name:	Middle Initial:
Permanent Residence Street Address:		Daytime Phone Number: ()	
City:	State:	ZIP Code:	Evening Phone Number: ()

Section 2 – Prescription Information		
Medication Name:	Date Filled:	Quantity:
Directions:		Total Price w/ Tax:
Medication Name:	Date Filled:	Quantity:
Directions:		Total Price w/ Tax:

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Claimant Signature X

Warning: It is a crime to provide false information or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any persons knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.