Inland Empire Health Plan
Pharmacy Reimbursement Request

Section 1: Member Information		
Member Last Name	First Name	Contact Number
Member ID		Date of Birth
Street address		

Section 2: Type of claim

- ○ Medical
- ○ Prescription
- ○ Vaccine only
- ○ Vaccine and injection
- ○ Injection

Section 3: Instructions

Submit this claim form, a copy of the receipt and Pharmacy print out to IEHP

Section 4: Required information for claim process

Your claim receipt/Pharmacy print out must contain the following information in order to be processed for payment. If below the information is not received, your claim cannot be processed and will be denied for missing information.

- ○ Pharmacy name, address, phone
- ○ Medication name, strength and form
- ○ Date of service (must be within 3 years)
- ○ Prescriber full name
- ○ Medication quantity
- ○ Total amount paid for medication
- ○ National Drug Code (NDC)

Section 5: Reason for request

Section 6: Signature

The above statements and attachments are true and complete to the best of my knowledge

X _____ _____

Signature Date

Claim submission is not a guarantee of payment. Non-Formulary medications are subject to prior authorization. Claim must be submitted within 3 years from the Date of Service.

Claim Mailing Address:
IEHP Member Services Department
P.O. Box 1800
Rancho Cucamonga
CA 91729-1800

Questions?
Call IEHP Member Services:
1-800-440-IEHP (4347)
8:00a.m.-8:00p.m. (PST)
TTY/TDD users should call 1-800-718-4347

Legal Notice: 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 and criminal penalties.