

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		
<input type="radio"/> Medical	<input type="radio"/> Vaccine only	<input type="radio"/> Injection
<input type="radio"/> Prescription	<input type="radio"/> Vaccine and 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.		
<input type="radio"/> Pharmacy name, address, phone	<input type="radio"/> Medication quantity	
<input type="radio"/> Medication name, strength and form	<input type="radio"/> Total amount paid for medication	
<input type="radio"/> Date of service (must be within 1 year)	<input type="radio"/> National Drug Code (NDC)	
<input type="radio"/> Prescriber full name		
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 1 year 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.