



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 Member Name: Address:		II. Prescript	II. Prescription Plan Information Insured's Member ID Number:		
		Insured's Mem			
		Group Number	Group Number:		
Birth Date:		Phone:	Employer:		
III. Patient Inform	nation				
Relationship to insur	ed: □Self	□Spouse □Dep	endent 🗖 Other:		
□Yes □No		-		edicare, or other government plans?	
	_		e:		
If yes, name of the al	ternate cove	rage (group name,	employer, association, etc):		
Patient illness or inju	ry (if injury,	include a descripti	ion of the accident, including date	and place).	
Did condition result	from employ	ment?			
			rior to treatment for which claim	was made:	
☐ Yes ☐ No	If yes, date	you last worked p	rior to treatment for which claim	was made:	
☐ Yes ☐ No	If yes, date	you last worked p	rior to treatment for which claim	was made:	
☐ Yes ☐ No IV. Prescription In	If yes, date nformation be complete	you last worked p	dispensing pharmacist. One pres	cription label should be attached fo	for each
☐ Yes ☐ No IV. Prescription In This section must	If yes, date nformation be complete	you last worked p	lispensing pharmacist. One pres de a copy of your pharmacy rece	cription label should be attached for ipt with this form.	for each
☐ Yes ☐ No IV. Prescription In This section must	If yes, date nformation be complete	you last worked p	dispensing pharmacist. One pres	cription label should be attached for ipt with this form.	or each
Did condition result Yes No IV. Prescription In This section must Pharmacy Name: RX Number:	If yes, date nformation be complete	you last worked p	lispensing pharmacist. One pres de a copy of your pharmacy rece	cription label should be attached for ipt with this form.	For each
☐ Yes ☐ No IV. Prescription In This section must Pharmacy Name: RX Number:	If yes, date nformation be complete	you last worked p	dispensing pharmacist. One pres de a copy of your pharmacy rece Pharmacy Address:	cription label should be attached for ipt with this form. Quantity:	for each
☐ Yes ☐ No IV. Prescription In This section must Pharmacy Name: RX Number: RX Name & Strength:	If yes, date nformation be complete prescr	you last worked p	dispensing pharmacist. One pres de a copy of your pharmacy rece Pharmacy Address: Date Filled:	cription label should be attached for ipt with this form. Quantity:	or each
☐ Yes ☐ No IV. Prescription In This section must Pharmacy Name:	If yes, date nformation be complete prescr	you last worked p	dispensing pharmacist. One pres de a copy of your pharmacy rece Pharmacy Address: Date Filled: Days Supply (30,60	Quantity: Comments:	or each
☐ Yes ☐ No IV. Prescription In This section must Pharmacy Name: RX Number: RX Name & Strength: Pharmacy Name:	If yes, date nformation be complete prescr	you last worked p	dispensing pharmacist. One pres de a copy of your pharmacy rece Pharmacy Address: Date Filled: Days Supply (30,60 Price:	Quantity: Comments:	or each
☐ Yes ☐ No IV. Prescription In This section must Pharmacy Name: RX Number: RX Name & Strength: Pharmacy Name: RX Number:	If yes, date nformation be complete prescr	you last worked p	dispensing pharmacist. One preside a copy of your pharmacy received Pharmacy Address: Date Filled: Days Supply (30,60) Price: Pharmacy Address:	Comments: Quantity: Quantity:	for each
☐ Yes ☐ No IV. Prescription In This section must Pharmacy Name: RX Number: RX Name & Strength: NDC #:	If yes, date nformation be complete prescr	you last worked p	dispensing pharmacist. One pres de a copy of your pharmacy rece Pharmacy Address: Date Filled: Days Supply (30,60) Price: Pharmacy Address: Date Filled:	Comments: Quantity: Quantity:	for each

Signature:

Date signed:_____