



4665 Business Center Drive
Fairfield, California 94534

PRESCRIPTION REIMBURSEMENT REQUEST

As of January 1, 2022, Medi-Cal Rx manages your Medi-Cal pharmacy benefits. If you need to be reimbursed (paid) for medications you paid for **on or after January 1, 2022**, call Medi-Cal Rx Call Center at **(800) 977-2273** for help.

To be reimbursed for medications you paid for **before January 1, 2022**, complete sections A through C below. You will also need to send proof of payment and the pharmacy receipt(s). The pharmacy receipt(s) are given to you with the medication warnings. They are not the receipt from the cash register.

Mail the completed form and pharmacy receipt(s) in the enclosed postage paid envelope or fax them to (530) 223-2508, Attention: Enrollment Unit or mail it to us at:

Partnership HealthPlan of California
Attention: Enrollment Unit
3688 Avtech Parkway
Redding, CA 96002

If you need help, call us at (800) 863-4155 Monday through Friday from 8 a.m. to 5 p.m. TTY users can call the California Relay Service at (800) 735-2929 or call 711.

Section A- Who were the medications for?

Member Name: _____ Phone #: _____

PHC ID #: _____ DOB: _____

Section B- Reimbursement Information:

Total number of prescription(s) you are submitting _____ Total amount requesting: \$ _____

If approved, to whom do we make the check out to? _____

Where do we mail the check? _____



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Section C- Why did you pay for the prescription(s).

Sample Receipt

Anytime Pharmacy #1234	
123 Any Street	(509) 555-1234
Home Town, US 12345-6789	Store NPI: 1234567890
RX:1234567	Date Filled: 1/1/2000
DOR: JANR	
DOB: 01/01/1900	
456 Home Road	(509) 555-5678
Home Town, US 12345	
Amoxicillin 500 mg capsule (Tera)	DAW: 0
00000 1111 22 QTY: 45	Days Supply: 30
NDC: 456790123	
A. SMITH, MD NPI# 10210	
U&C: 200.00	PAY: 20.00

PHC USE ONLY

Make check out to:	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Mail to: 4665 Business Center Dr. Fairfield CA 94534	<input type="checkbox"/> Force to pay	
Amount approved for payment: \$ _____		
Authorized Signature	Date:	
MEDIMPACT Use Only		
Completed by:	Date:	