A PLAN YOU CAN COUNT ON ...
AND PEOPLE YOU CAN TRUST

PRESCRIPTION NETWORK

If you are a Plan Member and have a prescription you paid for and need to have processed for reimbursement, complete the following information and return it to the Prescription Network office. Your request for reimbursement MUST be accompanied by a copy of the prescription claim receipt (NOT a cash register receipt) in order for your claim to be processed:

Group Name: _____

Subscriber Name: _____

Subscriber ID Number: _____

Patient Name: _____

Address where reimbursement should be sent (reimbursement check will be made out to the Subscriber, regardless of the address you supply):

_____

_____

Phone Number: _____
(This will only be used in the event we have questions about your claim).

ATTACH A COPY OF THE PRESCRIPTION RECEIPT(S) WHICH YOU ARE REQUESTING REIMBURSEMENT FOR.

Submit this completed form, along with your receipt copies to:

Mail: Prescription Network
3512 SW Fairlawn Rd, Ste 300
Topeka, KS 66614

Fax: 785-228-3951

If you have any questions, contact the Prescription Network office at 1-800-279-3022.