



Cardinal Health Alliance

HMO Prescription Reimbursement Form

Date of Service (s) _____

Time of Service _____

Name of Physician Prescriber _____

Advantage Member Number _____

Name of Pharmacy _____

Pharmacy Location _____

Reason for Reimbursement _____

Patient Name on the Prescription _____

Employee Name _____

You must attach your receipts and send all to Cardinal Health Alliance, 300 N. Pauline Ave., Muncie, In 47303 or send via inter-office mail.

Your Signature

Date