

PRESCRIPTION DRUG CLAIM FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

SCHOOL/ORGANIZATION		POLICY NUMBER (CAN BE FOUND ON ID CARD)	
INSURED'S LAST NAME		INSURED'S FIRST NAME	MI
INSURED'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #)			APT./UNIT #
CITY		STATE	ZIP
INSURED'S DATE OF BIRTH (MM/DD/YY)	FEMALE MALE	INSURED'S SCHOOL ID NUMBER	INSURED'S PHONE NUMBER

PROCESSING INFORMATION

Were you prescribed this medication due to an Injury? No Yes If yes, complete the section below.

Description of Injury: _____

Date of Injury: _____

Do you have *other* insurance which covers your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? No Yes

If yes, who is the Policyholder? Self Parent Spouse Name of Insurance Carrier: _____

Member No.: _____ Group No.: _____ Insurance Co. Phone No.: _____

Primary Insured's Name (Parent/Spouse/Self): _____

CLAIM FILING INSTRUCTIONS

Complete the information above and submit pharmacy receipt(s), which include the following information:

- Pharmacy name
- Rx number
- Patient's name
- Name of the medication(s)
- Prescribing physician's name
- Dosage or quantity dispensed
- NDC code number
- Date of service
- Amount charged

IMPORTANT: Cash register receipts will not be accepted. You must submit the receipt from the pharmacy that includes the drug information.

YOU CAN SUBMIT THIS COMPLETED FORM BY MAIL OR FAX USING THE INFORMATION BELOW. CLAIMS ARE NOT ACCEPTED VIA EMAIL.

Claims Mail: Relation Insurance Services, P.O. Box 25936, Overland Park, KS 66225
Claims Fax: (913) 327-7520
Customer Service: (877) 246-6997
Customer Service E-mail: claims@relationinsurance.com