

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) | <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE | INSURED'S SCHOOL ID NUMBER | INSURED'S PHONE NUMBER |

PROCESSING INFORMATION

Were you prescribed this medication due to an Injury? Yes No 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)? Yes No

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, Kansas 66225
Claims Fax: (913) 327-7520
Customer Service: (800) 483-6192