Relation™
EDUCATION SOLUTIONS

Relation Insurance Services
P.O. Box 25936
Overland Park, KS 66225

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? ☐ 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, KS 66225
Claims Fax:	(913) 327-7520
Customer Service:	(877) 246-6997
Customer Service E-Mail:	claims@relationinsurance.com

Clear Form