



PRESCRIPTION DRUG CLAIM FORM

Cardholders Name (last, first, MI)	Date of Birth	Gender (circle) M F	Cardholder ID Number
Check if new address			
Street _____			
City/State _____	Zip Code _____	Daytime Telephone() _____	
Employer	Group Number		

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to The PerfectHealth Insurance Company, Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Cardholder's Signature _____ Date _____

PATIENT INFORMATION (PLEASE LIST INFORMATION FOR EACH PATIENT SUBMITTING CLAIMS)

1	Patient's Name	Relationship to Cardholder? (circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	Total Number Of receipts attached:
Pharmacy Name and Address				Physician Name (name of prescribing Doctor)	

2	Patient's Name	Relationship to Cardholder? (circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	Total Number Of receipts attached:
Pharmacy Name and Address				Physician Name (name of prescribing Doctor)	

3	Patient's Name	Relationship to Cardholder? (circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	Total Number Of receipts attached:
Pharmacy Name and Address				Physician Name (name of prescribing Doctor)	

PRESCRIPTION INFORMATION

- ✓ **IMPORTANT ALL prescription claims must have prescription receipts/labels which include:** • Pharmacy Name/Address • Date Filled • Drug Name, Strength and NDC • Rx Number • Quantity • Days Supply • Price • Patient's Name
- ✓ Please tape receipts to separate 8x10 piece of paper (please keep a copy for your records).
- ✓ Patient history print outs from the pharmacy are also acceptable but MUST be signed by the Pharmacist.
- ✓ CASH REGISTER RECIEPTS ARE **NOT** ACCEPTABLE FOR ANY PRESCRIPTIONS.

Mail completed Claim form and receipts to:

The PerfectHealth Insurance Company
55 Water Street, 5th Floor
New York, New York 10041