

PRESCRIPTION DRUG CLAIM FORM



PO Box 7068
Eugene, Oregon 97401
(541) 686-1242 or (800) 624-6052
Fax (541) 344-2897
www.pacificsource.com

EMPLOYER/GROUP NAME			GROUP NO.	
EMPLOYEE'S LAST NAME	FIRST NAME	M.I.	IDENTIFICATION NO.	BIRTH DATE
ADDRESS		CITY	STATE	ZIP
PATIENT'S LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO EMPLOYEE: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	

Only prescription drugs sold by a licensed pharmacist will be considered for coverage under your policy.

All prescriptions must contain the following information in order to be processed:

- Name of dispensing pharmacy
- Name of prescribing doctor/nurse practitioner
- Date prescription was filled
- Name and strength of medication
- Quantity of drug dispensed

PLEASE ATTACH ALL PRESCRIPTION RECEIPTS BELOW.
