

Prescriptions were dispensed to: (Please Print)

Note: Use a separate claim form for each covered member of the family.

First Name Middle Name Last Name

ID# on Presbyterian ID Card SSN# Date of Birth

Address City State ZIP Code Phone (including area code)

Guardian Name or Cardholder Relationship

- Is this medication for an on-the-job injury? Yes ___ No ___
- Is this medication covered under any other group insurance plan? Yes ___ No ___
- If yes, provide the name of the insurance company and other employer

ID number for other ins Employer Name for other Ins Phone Number for other ins

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Printed Name _____ Signature _____
Patient (or Parent if a Minor)

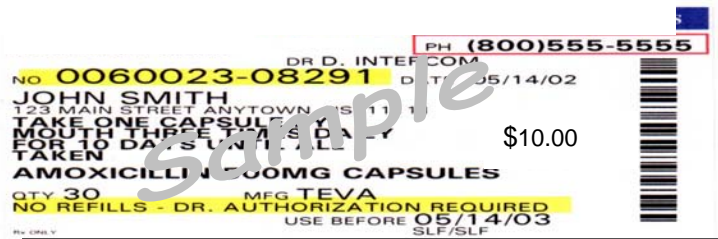
★ Please attach the duplicate pharmacy generated receipt to this form. ★
If it is unavailable, please have the pharmacy or dispensing facility print a pharmacy patient profile
There is a filing deadline. Please file your reimbursement claims as soon as possible

Instructions for Filing a Pharmacy Claim:

Claims for prescriptions must include a pharmacy receipt or member profile. Information must include:

- | | |
|---|---|
| Patient's Name | Date of Purchase |
| Prescription Number | Pharmacy Name, Address, Phone number and NABP number |
| Drug Name, Strength, Quantity, and Frequency | Prescribing Doctor Name and Phone number |

Cash register receipts are not acceptable.



Attach pharmacy receipts here

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If additional room is needed please use a separate form

After Completing all sections above please mail this form and any additional information to assist in paying your claim to:
Presbyterian – Attn: Pharmacy Services
PO Box 27489, Albuquerque, NM 87125