Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

PRESCRIPTION CLAIM FORM

Please read reverse side before completing this form.
Your claim cannot be processed unless this form is complete.

INSURED INFORMATION: TO BE COMPLETED BY INSURED

Insured's Social Security #: - - Ins. Carrier:______________________________

Employer:______________________________

Insured's Name______________________________ Group Number: ___ ___ ___ ___ ___
Last First M.I.

Insured's Address______________________________ Home Phone ( )______________________

______________________________ Work Phone ( )______________________

Check if new address.

Patient Name______________________________ Patient Birth date______________________
Last First M.I.

Relationship to Insured: Insured Spouse Dependent Other______________________

PRESCRIPTION INFORMATION:

This section must be completed by you or your dispensing pharmacist. Prescription receipts should be attached, one to each section.

Pharmacy Name______________________________ Rx. No. ______________________
Address______________________________ Date Filled______________________
Drug Name & Strength______________________________Quantity ______________________
NDC #______________________________Price Paid $______________________
Reason for claim not submitted by pharmacy ______________________________

Pharmacy Name______________________________ Rx. No. ______________________
Address______________________________ Date Filled______________________
Drug Name & Strength______________________________Quantity ______________________
NDC #______________________________Price Paid $______________________
Reason for claim not submitted by pharmacy ______________________________

Pharmacy Name______________________________ Rx. No. ______________________
Address______________________________ Date Filled______________________
Drug Name & Strength______________________________Quantity ______________________
NDC #______________________________Price Paid $______________________
Reason for claim not submitted by pharmacy ______________________________

Pharmacy Name______________________________ Rx. No. ______________________
Address______________________________ Date Filled______________________
Drug Name & Strength______________________________Quantity ______________________
NDC #______________________________Price Paid $______________________
Reason for claim not submitted by pharmacy ______________________________

PLEASE SIGN AND DATE HERE.

I certify that the information is correct and that the prescriptions listed above are for myself or for members of my family who are eligible. I have received the medication described above and authorize release of all information contained on this claim to Scott & White Prescription Services and my plan sponsor.

_____ _____

Insured's Signature Date Signed

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND FILL OUT REVERSE SIDE OF THIS FORM.

A SEPARATE FORM MUST BE COMPLETED FOR EACH PATIENT.

INSURED INFORMATION: (INSURED IS THE PERSON WHOSE EMPLOYER PROVIDES THIS BENEFIT.)

1. Print insured's social security number or member I.D. number.
2. Please tell us if you have a new address.
3. Print insured's name (last, first, M.I.), address and phone number.
4. Print patient's name (last, first, M.I.), address and phone number.
5. Print patient's birth date.
6. Indicate patient's relationship to insured (i.e. spouse, daughter, son).

PRESCRIPTION INFORMATION:

Please attach prescription receipt for each prescription. If one is not available, you may request a medication printout from the pharmacy where prescriptions were filled. Pharmacy printouts must include the following:

Pharmacy Name & Address
Rx Number
Drug Name & Strength
Date Filled
NDC Number
Quantity
Price

QUESTIONS?
Call Scott & White Health Plan Pharmacy Department at 1-800-728-7947.

FAX TO: 1-866-880-4532

MAIL TO: Scott & White Pharmacy Department
1206 West Campus Drive
Temple, TX 76502