PRESCRIPTION DRUG CLAIM FORM

PO Box 70088
Springfield OR 97475-0105
Phone: 888.532.5332
Fax: 541.225.3658
PacificSource.com/PSA

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: ☐ SELF ☐ SPOUSE ☐ 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.