

Drug Claim Form

Member information (See other side for instructions)

ID number

Group number

Date of birth / / Male Female

Name (First, Last) _____

Street address _____

City _____ State _____ Zip _____

Member's relationship to primary cardholder:
 Self Spouse/Domestic partner Dependent/Child

I certify that:
• The information on this form is correct

Instructions

- 1.