# PRESCRIPTION DRUG & SUPPLIES CLAIM FORM

## INSTRUCTIONS

- Complete this form for each family member.
- Attach Prescription receipts to this form and Mail to:

**TPSC Benefits Claims Administrator:**
P.O. Box 2950; Tacoma, WA 98401

**Phone:** 253.564.5611 ext. 210
**Fax:** 253.564.5881
**Toll Free:** 800.426.9786 ext. 210

## MEMBER/INSURED INFORMATION

| | | |
|---|---|---|
| Last Name: | First Name: | M.I.: |
| Birth Date: | Social Security #: | |
| Address: | | |
| City: | State: | Zip: ☐ Check if New Address |
| Phone #: | Sex: ☐ Male ☐ Female | Marital Status: ☐ Married ☐ Single |
| Name of Employer: | | |
| Group #: | Date Employed: | Job Position/Duties: |

**Is coverage for this expense provided by any other group insurance, federal program (including medicare), employer union, student or association plan?**

☐ Yes ☐ No

If "yes", provide name and address of insurance company and policy number:

| | |
|---|---|
| Name of Patient: | |
| Birth Date: | Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other |

| Type of Illness or Injury | Rx # | Date of Purchase | Name of Pharmacy | Name of Drug &/ or Supply | Check if Generic | Amount Paid | Prescribing Physician |
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**I HEREBY CERTIFY THAT THE PRESCRIPTION DRUGS AND/OR SUPPLIES LISTED ABOVE WERE NECESSARY FOR THE TREATMENT OF THE ILLNESS OR INJURY REPORTED AND WERE PURCHASED FOR THE INDIVIDUAL NAMED ABOVE.**

Signature of Subscriber or Patient

Date