Stephens County Hospital
Prescription Drug Claim Form

Mail: Core Management Resources
P.O. Box 90
Macon, GA 31202
Fax: 478-750-1705
Email: help@corehealthbenefits.com

This form can be used for both medical plan I and II
Group Number: 925

PRESCRIPTION DRUG CLAIM FORM

Action required:

1. Enter all requested information in the space provided on this form. Failure to provide all requested information will delay the process.
2. Attach all receipts showing the name and address of the pharmacy, name of patient, date of purchase, prescription number, name of medication and the charges.
3. Sign and date this form.
4. Mail, fax or email the completed form and supporting documentation to the address fax number or email address listed above.

PATIENT INFORMATION			SUBSCRIBER INFORMATION	
PATIENT NAME: Last First MI			SUBSCRIBER ID NUMBER:	
DATE OF BIRTH:	SEX: ❑ M ❑ F	RELATION TO MEMBER: ❑ Self ❑ Spouse ❑ Child	SUBSCRIBER NAME: Last First MI	
PATIENT ADDRESS:			SUBSCRIBER ADDRESS:	
DAYTIME TELEPHONE #: ( )		DATE OF BIRTH:	DAYTIME TELEPHONE #: ( )	DATE OF BIRTH:
Total # of Receipts Submitting:			Total Amount Submitting: $	

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Member, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

MEMBER'S SIGNATURE: _____

DATE: _____