



APWU HEALTH PLAN
 P.O. BOX 967 SILVER SPRING, MD. 20910
 PHONE: 800-222-APWU

CARRIER USE ONLY

PRESCRIPTION DRUG CLAIM FORM

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. INSURED'S SOCIAL SECURITY NUMBER _____

2. INSURED'S NAME & ADDRESS _____

 (IF ADDRESS INCORRECT, PLEASE CORRECT ABOVE)

3. PATIENT (CHECK PATIENT'S NAME: ONLY ONE PATIENT PER CLAIM FORM)
 ENTER FIRST NAME (IF NOT LISTED ABOVE) _____
 (PLEASE ADVISE THE HEALTH PLAN IF THIS LISTING IS INCORRECT)

4. PATIENT'S DATE OF BIRTH _____

5. PATIENT'S SEX: MALE FEMALE

6. DOES PATIENT HAVE MEDICARE? IF YES, PLEASE INDICATE EFFECTIVE DATE AND ATTACH EOMB FROM MEDICARE CARRIER.
 PART "A" EFFECTIVE DATE _____ PART "B" EFFECTIVE DATE _____

7. IS PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE? YES NO
 IF YES, PLEASE INDICATE NAME OF POLICYHOLDER, PLAN NAME, ADDRESS, POLICY NO. AND PHONE NO. IF NO, PLEASE SIGN AND DATE.
 IF YES, PLEASE ATTACH PAYMENT STATEMENT FROM OTHER CARRIER.

8. WAS CONDITION RELATED TO:
 A. PATIENT'S EMPLOYMENT? YES NO
 IF YES, INDICATE FILE NO. _____
 B. AN AUTO/MOTORCYCLE ACCIDENT? YES NO
 (PLEASE CIRCLE ONE)
 IF YES, PLEASE ATTACH PAYMENT STATEMENT.

9. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE AUTHORIZING THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.
 SIGNED: _____ DATE: _____

CLAIMS FILING INSTRUCTIONS: Please Print

The member must complete and sign this form.
 You must attach supporting receipts. Cancelled checks or balance due statements are not acceptable. Please list purchases in date order.
 1. Non-prescription items and over-the-counter drugs are not covered.
 2. Use a separate form for each family member.
 3. Claims must be submitted within two years of the date you incur the expense. Failure to file within the two year limit will invalidate your claim.

Date of Purchase	Rx Number	Brand or Generic Name of Drug	Doctor Prescribing Drug	Charge for Drug

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NOTE: If additional space needed, use reverse side.

I certify the Rx drugs listed were purchased for the patient named and **DO NOT** include drugs that can be purchased **OVER THE COUNTER** with or without a doctor's prescription.

 Supplier's Federal Tax ID Number

 Pharmacist's Signature

 Pharmacy Name and Address

I certify the above statement to be correct.

 Date

 Member's Signature