Prescription Claim Form

Member's Name: _____

Member's ID #: _____

Member's Address: _____

_____

Patient's Name: _____

Patient's Date of Birth: _____

Please attach detailed prescription receipt(s) here, including the following information:
Pharmacy Information, Rx Number, Date Filled, NDC, Quantity, Days' Supply, and Amount Paid by Member.

Send completed form to:
Prescryptive Health, Inc
Attention: Member Services
PO Box 403
Redmond, WA 98073

Or send via secure fax to: 360-802-5116