PRESCRIPTION DRUG CLAIM FORM - COORDINATION of Rx BENEFITS

This form is to provide direct reimbursement for prescriptions with coordination of other benefits. In order to process your claims in a timely manner, you must provide all information requested below. Receipts MUST be attached. Please use a separate claim form FOR EACH PATIENT.

INSURED INFORMATION		
Insured's Name:_____	**Carrier #:** _____	**Group #:** _____
Street Address: _____	**ID#:** _____	**Patient ID Code:** _____
City: _____	**State:** _____	**Zip:** _____

I certify that the information provided is correct and that the patient indicated below is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this claim form to the East End Health Plan and the plan administrator. I agree that any benefit payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

INSURED'S SIGNATURE: _____ **DATED:**_____

PATIENT INFORMATION	
Patient's Name: _____ **Patient's D/O/B:** _____ **Male_____ Female_____** **Patient's Relationship to Insured:** **Self_____ Spouse_____ Dependent_____** **Check if Full-Time Student** _____	**Return completed form, including the pharmacy receipt, in a sealed envelope to:** **East End Health Plan - Rx Drug COB Processing Unit** **309 South Franklin Street** **2nd Floor** **Syracuse, NY 13202** **Please allow for approximately 3-5 weeks for processing time.**

PRESCRIPTION CLAIM INFORMATION				
1. Rx #: _____	**NEW** _____	**or**	**REFILL** _____	**TOTAL COST:** $_____
2. Rx #: _____	**NEW** _____	**or**	**REFILL** _____	**TOTAL COST:** $_____