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
120 Walton Street
Suite 500
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: $__________
3. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
4. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
5. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
6. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
7. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
8. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
9. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
10. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
11. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
12. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
13. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
14. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
15. Rx #: ______________	NEW ____ or REFILL ____	TOTAL COST: $__________
		TOTAL $ __________