DELTA HEALTH SYSTEMS

REFER TO YOUR I.D. CARD FOR PROPER MAILING ADDRESS

EMPLOYEE ID NUMBER

			-					

PRESCRIPTION DRUG CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION

1. PATIENT'S NAME	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME
	| |	
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE ☐ FEMALE ☐ 7. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	6. EMPLOYEE'S ADDRESS (STREET, CITY, STATE, ZIP CODE) ☐ CHECK HERE IF NEW ADDRESS

8. OTHER HEALTH INSURANCE COVERAGE
IS PATIENT COVERED BY ANY OTHER PLAN? ☐ YES ☐ NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER:

IDENTIFICATION NUMBER _____ NAME OF EMPLOYER _____

TYPES OF COVERAGE BY CARRIER: ☐ MEDICAL ☐ DRUG ☐ DENTAL ☐ VISION

EFFECTIVE DATE OF COVERAGE _____ TERMINATION DATE OF COVERAGE _____

9. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.	10. WAS CONDITION RELATED TO ACCIDENT? ☐ YES ☐ NO 11. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT? ☐ YES ☐ NO
_____ _____ SIGNED (EMPLOYEE OR PATIENT) DATE	DETAILS: _____

PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER

ATTACH ITEMIZED PHARMACY RECEIPTS HERE

59083 - K/P CORPORATION - MEDICAL SYSTEMS - (209) 466-6761