



PRESCRIPTION CLAIM FORM

INSTRUCTIONS

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE FILLING OUT THE FORM.

A SEPARATE FORM MUST BE COMPLETED FOR EACH PATIENT

INSURED INFORMATION: (Insured is the person whose employer provides the benefit)

1. Print insured's social security number or member I.D. number.
2. Please tell us if you have a new address.
3. Print insured's name (last, first, M.I.), address and phone number.
4. Print patient's name (last, first, M.I.), address and phone number.
5. Print patient's birth date.
6. Indicate patient's relationship to insured.

PRESCRIPTION INFORMATION:

Please attach prescription labels for each prescription. If one is not available, the information must be filled out by your pharmacist and receipts attached.

QUESTIONS? Call Scott & White Prescription Services at **1-800-728-7947**

MAIL TO:

Scott & White Prescription Services
Attn: Sherry Lopez
4236 Lowes Drive
Temple, Texas 76502

