Relation™

Prescription Drug Claim Form

MEMBER INFORMATION:

Student's Name (Last, Middle, First) ______________________________

College/University Name ______________________ Student ID ______________________

Address ______________________________

City ______________________ State ____________ Zip ____________

Phone Number ____________ Date of Birth ____________ Gender ☐ Male ☐ Female

☐ Check here if this is a new address

PROCESSING INFORMATION:

Were you prescribed this medication due to an Accident? ☐ Yes ☐ No ➢ **If Yes**, complete the section below.

Date of Accident ______________ Description of Accident ______________________

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Do you have any other insurance coverage? ☐ Yes ☐ No ➢ **If Yes**, complete the section below.

Insurance Company Name ______________________ Phone Number ______________

Address ______________ City ____________ State ____________ Zip ____________

Group Number ____________ ID Number ____________ Effective Date ____________ Termination Date ____________

Claim Filing Instructions:

- ✓ Completely fill out the above information.
- ✓ Submit **Pharmacy receipt**(s) which include the following information:
  - Drug Number (NDC code)
  - Drug Name
  - Date Filled
  - Prescribing Physician
  - Dosage
  - Units

IMPORTANT: Cash register receipts will not be accepted.
You must submit the receipt from the pharmacy that includes the drug information.

You can submit your pharmacy claim by mail, e-mail or fax using the information below.

Mail This Form To:
Relation Insurance Services
Attn: Rx Claims Department
PO Box 25936
Overland Park, KS 66225

E-Mail This Form To:
claims@relationinsurance.com

Fax This Form To:
(800) 346-9169

Benefits are administered by Relation Insurance Services. Please call **206-909-8550 (WA) or 503-729-7447 (OR)** with all questions.