

MediScript Prescription Program Claim



I. MEMBER INFORMATION

MEMBER NAME (LAST, FIRST, MI)		SOCIAL SECURITY NO./CONTRACT NO.	DATE OF BIRTH (MO, DAY, YR)
GROUP NUMBER *MEMBER NOT TO COMPLETE			
FLBCS			
ADDRESS (Complete only if address has changed)			SEX
CITY, STATE, ZIP CODE			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

II. PATIENT INFORMATION (Must be completed if patient is a dependent child or spouse)

PATIENT NAME (LAST, FIRST, MI)		DATE OF BIRTH (MO, DAY, YR)	
ADDRESS (If different than member)		SEX	RELATIONSHIP
CITY, STATE, ZIP CODE		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> DISABLED DEPENDENT CHILD

III. GENERAL INFORMATION

A. Was condition related to an accident? <input type="checkbox"/> YES <input type="checkbox"/> NO Accident Date ____ / ____ / ____ If yes, was it related to: <input type="checkbox"/> Auto Accident <input type="checkbox"/> Workers' Comp <input type="checkbox"/> Other _____	
B. Is other insurance applicable to charge? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete the information below. You must submit an EOB for your claim to be processed. Other Carrier Name _____ Policy # _____ Name of Subscriber _____ Amount Paid By Other Insurance \$ _____	

IV. CERTIFICATION AND AUTHORIZATION

I certify all information provided on this form and on the attached itemized statement to be true and correct to the best of my knowledge.	
MEMBER/PATIENT SIGNATURE	DATE