



## *Prescription Reimbursement Form*

***\*Please attach the actual pharmacy receipt to include prescription name, Doctors Name, and cost of drug. This information must be submitted to the address below within 90 days to remain eligible\****

Member Id #: 999- \_\_\_\_\_

Member name: \_\_\_\_\_

Claimant Id #: 999- \_\_\_\_\_

Claimants name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Is this a new address? Yes / No

Date of Sickness / Injury: \_\_\_\_\_

Sickness / Injury (Diagnosis) that this prescription is related to:

\_\_\_\_\_

*Sincerely,*

*GBG Administrative Claims Dept*