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.

______ SIGNED (EMPLOYEE OR PATIENT) ______ DATE

10. WAS CONDITION RELATED TO ACCIDENT? ☐ YES ☐ NO
11. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

DETAILS: ______

PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER

ATTACH ITEMIZED PHARMACY RECEIPTS HERE

SAMPLE RECEIPT

NAME & ADDRESS OF PHARMACY
PRESCRIBING PHYSICIAN
RX #
DATE FILLED
PATIENT NAME
NAME OF DRUG
QTY OR DAYS SUPPLY
NATIONAL DRUG CODE
PRICE

DELTA DRUG STORE PRESCRIPTION RECEIPT
1234 W. OUR STREET - STOCKTON, CA. 95203
123456-1 DR. SMITH 01/01/93
JOHN SMITH 98765432
TAKE 1 TABLET 3 TIMES A DAY
TAGAMENT 100MG 120 $60.00
98D 2197 YSEF
71-0362-32

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