

Prescription Drug Claim Form

University of Washington Student Plan

Underwritten by MEGA Life and Health Insurance Company

UW HEALTH CLAIMS

P. O. Box 34600, Seattle, WA 98124-1600

(866) 535-8503 or (206) 374-9439

Student Name: _____

Student Address: _____

Social Security No.: _____

Patient Name: _____

Patient's Relationship to Student: _____

Is the patient covered under another medical health care plan? Yes No If yes, please provide the following information:

Company Name

Health Care Plan's Address (PO Box or Street, City, State, ZIP)

Policyholder's Name

Policyholder's Birth Date

Identification or Policy Number

Please read the following instructions before completing this section.

- A. Use this form for Prescription Drugs only.
- B. Use a separate form for each family member.
- C. List drug purchase in date order with the oldest one first.
- D. Attach copies of all drug receipts to the reverse side. Cash register receipts are not acceptable. If your pharmacy does not provide receipts, please have your pharmacist sign in the "Name of Pharmacy" column.

PRESCRIPTION NUMBER	NAME OF DRUG	ILLNESS	NAME OF PHARMACY	DATE OF PURCHASE	CHARGE

I authorize all health care providers and insurance companies to release any medical or related information necessary to process this claim. **It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and/or civil damages.**

Student Signature

_____/_____/_____
Date