Pearce Administration
Insurance Specialists since 1965

PO Box 2409, Florence, SC 29501
Phone: 888-722-1668

Prescription Drug Claim Form

Part One: To Be Filled Out By You

Date Submitted: ___/___/___

____
Member ID Number (can be found on your ID card)

____
Address (For Reimbursement Purposes)

____
City State Zip

( )______________________
Daytime Phone Number

____
Patient's Last and First Name

_____/______/_________
Date of Birth

Patient is:

Member [ ]
Spouse [ ]
Child [ ]

Place a X

Part Two: Medical and Drug Information

No. of Prescriptions Submitting: ________

Medical Condition Drug is prescribed for:

____

RX Slip #1

*Date prescription filled
*Name and Address of Pharmacy
*NDC Number
*Name of Drug and Strength
*Quantity
*Days Supply
*Amount Paid

****All of the above information must be on the slip.**

Medical Condition Drug is prescribed for:

____

RX Slip #2

*Date prescription filled
*Name and Address of Pharmacy
*NDC Number
*Name of Drug and Strength
*Quantity
*Days Supply
*Amount Paid

****All of the above information must be on the slip.**

Medical Condition Drug is prescribed for:

____

RX Slip #3

*Date prescription filled
*Name and Address of Pharmacy
*NDC Number
*Name of Drug and Strength
*Quantity
*Days Supply
*Amount Paid

****All of the above information must be on the slip.**

Medical Condition Drug is prescribed for:

____

RX Slip #4

*Date prescription filled
*Name and Address of Pharmacy
*NDC Number
*Name of Drug and Strength
*Quantity
*Days Supply
*Amount Paid

****All of the above information must be on the slip.**

Name of Institution or University Name:

____

Group Number: (Example: AIH0000XXX)

____

Note: All Pharmacy prescriptions are subject to the plan limitations and exclusions. All prescription claims are also subject to Pre-existing condition clauses outlined in the plan brochure or policy. Deductibles and co-payments will apply to any prescription claim submitted if stated in the plan brochure. A Claim form does not guarantee payment of the associated claim and some prescriptions may be denied on a individual basis if the plan exclusions do not allow for coverage of a particular drug.

Please attach all RX slips to this claim form, without a slip your claim would be invalid

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed above has (have) received the medication, and I authorize release of all information contained on this claim to Pearce Administration.

Member Signature______________________________

SEND ALL CLAIMS TO: Pearce Administration • PO Box 2409 • Florence, SC 29503-2409

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