CG | UNITED

PRESCRIPTION DRUG CLAIM

Claim No._____

Health Insurance

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF DATE PRESCRIPTION FILLED.

Please Email completed form (along with copies of receipts) to Medical_Claims_BB@cgcoralisle.com.

PART 1 PRIMARY INSURED

Surname _____ First Name _____ Middle Initial _____

Certificate No._____ Date of Birth (DD/MM/YY)_____

Mailing Address _____

Contact Nos. (H)_____ (W) _____(C) _____

PART 2 PRESCRIPTION(S) WERE FOR

Surname _____ First Name _____ Middle Initial _____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child Date of Birth (DD/MM/YY)_____

Is the patient covered by additional health insurance coverage? ☐ Yes ☐ No If Yes:

Other Carrier Name _____ (please include EOB of this Carrier)

PART 3 PHARMACY INFORMATION

Name of Pharmacy_____ VAT Reg. No._____

Address_____ Tel. No._____

DATE	RX NO.	DRUG ID (if given)	QTY	DESCRIPTION	PRICE
				Total Charges	
				VAT	
				Total Amount as shown on Receipt	

PART 4 DECLARATION

I hereby certify that the above is correct and complete and that I am claiming benefits only for the charges for the patient named above.

Primary Insured's Signature _____ Date _____