



BEST Life and Health Insurance Company

PRESCRIPTION REIMBURSEMENT CLAIM FORM - HDHP

Mail Completed Form To:

BEST Life and Health Insurance Company
P.O. Box 890 • Meridian, ID • 83890
(800) 433-0088 | Fax (208) 893-5040

IMPORTANT!

Always allow up to 21 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing. Make a copy of all documents submitted and do not staple or tape receipts or attachments to this form. No documents will be returned.

TO BE COMPLETED BY EMPLOYEE • Answer all questions that apply • Sign where indicated by arrows(➤).

Employee Name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number
Street Address		City	State	Zip () Phone ()
Employed by (Company Name and Address)		Policy No.	Occupation/Job Title	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed
Identification Number (refer to your prescription discount card)				

PATIENT INFORMATION • USE A SEPARATE CLAIM FORM FOR EACH PATIENT.

Claim is Made for Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Name of Claimant	Claimant's Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse's Date of Birth
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I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible to apply these costs to the plan's deductible and/or co-insurance. I also certify that the medication received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to BEST Life and Health Insurance Company, plan sponsor, policyholder and/or employer. I certify that all the information entered on this form is correct.

➤
Signature of Primary Member or Legal Representative

PRESCRIPTION CLAIM INFORMATION

NOTE: If you are including all original receipts with the following information, it is not necessary to complete this section. ONLY INCLUDE charges for prescription medications, original receipts and full itemized statements.

Rx	Rx #	Date Filed (m/d/y)	Prescriber's DEA No.	<input type="checkbox"/> New <input type="checkbox"/> Refill <input type="checkbox"/> DAW <input type="checkbox"/> Compound	For office use only Prior Approval Code
	NDC #	Drug Name and Strength	Metric Quantity	Days Supply	Total Charges