



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 • 83680  
(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.

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