DRUG CLAIM FORM

Taylor Benefit Resources, Inc.
P. O. Box 6580
Thomasville, GA 31758
(800)35 CLAIM or 229-225-9943

1. Attach itemized bills for covered Medical Expenses and Prescription Drugs.
2. Do not send canceled checks or cash register receipts. The actual bills are needed.
3. If you do not have itemized bills for your Prescription Drugs, you may have your Pharmacy complete the Prescription Drug Expense section below.

EMPLOYEE AND PATIENT INFORMATION — Employee's Social Security Number

Patient's Name (Last, First, Middle	Patient's Birthdate	Age	Employee's Name	Group Number:

Patient is: ___ Male Employee ___Female Employee ___ Husband of Employee ___ Wife of Employee ___ Son ___ Daughter	Employee's Street Address, City, State & Zip
Diagnosis or Nature of illness or Injury Requiring Treatment	Is this a new address? ___ Yes ___ No

Treatment was the Result of: (check one, if Applicable) ___ Accident ___ On-the-job-injury	Date of Accident or Injury:	Does patient have any other group health Insurance? ___Yes ___ No If "yes", please give the following information
Name of Insuring Company	Name of Policyholder	Identification of Policy Number
Company's Address (Street or P.O. Box)	City	State & Zip Code

I authorize release to or by Administrative Claim Service of any medical or insurance information required to process my claim. A photocopy of this authorization may be honored.

Employee's Signature______________________________ Date______________

PRESCRIPTION DRUG EXPENSE (use a separate form for each Pharmacy)

Date of Purchase	Prescription Number	Name of Drug	Charge	Physician
		Total Charge		

For the Pharmacist:
I hereby certify that these drugs and medicines were dispensed for the above-named person by order of his (or her) personal physician; and that all the charges listed were only for those drugs and medicines which require by law a written and/or oral order by a licensed physician, and that the total charge shown below is accurate for such drugs and medicines. I also certify that these drugs and medicines were dispensed under existing state and federal laws and that any false statement makes me personally liable under these laws.

Name of Pharmacy or Dispensary	Phone Number	Pharmacist's License Number	Total Charge
Street Address	City State	Signature of Pharmacist	