CG | INSURANCE

PRESCRIPTION DRUG CLAIM

Claim No.________________________________

Premier Health

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

Please submit completed form along with receipts (do not staple to form) via
Email: Medical_claims_BM@cgcoralisle.com or Fax: 441 295 9036

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 ____

Address ____ Tel. No. ________________

DATE	RX NO.	DRUG ID (if given)	QTY	DESCRIPTION	PRICE
				Total Charges	

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 ____________________