



PRESCRIPTION DRUG CLAIM FORM

Employer's Name: _____

Employee's Name: _____

Employee's SSN or ID Number: _____

Patient's Name: _____

Patient's Relationship to Employee: _____

Please attach the prescription receipt (which includes name of drug, dosage and cost)
along with the cash receipt to this form and forward to:

Self Funding Administrators Corporation
Claims Center
Post Office Box 6596
Annapolis, Maryland 21401

This form is to be used **ONLY** for prescription drug charges incurred
PRIOR to receiving your own personal prescription drug card.