



## PRESCRIPTION DRUG CLAIM FORM

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Employer's Name: \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Employee's SSN or ID Number: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Patient's Relationship to Employee: \_\_\_\_\_

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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**

Post Office Box 46511

Cincinnati, Ohio 45246

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