

COMMEDCIAL	PRESCRIPTION	DPIIG C	I AIN
COMMERCIAL	PRESCRIPTION	DRUG C	

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						
Surname			Middle Initial			
Certificate No				Date of Birth (DD/MM/YY)_		
Mailing Address						
Contact Nos. (H)		(W)_	(C)_		
PART 2	RESCRIPTION	N(S) WERE	FOR			
Surname		First Name			Middle Initial	
Relationship to	nsured 🗆 S	elf 🗖 Spou	se 🗆 Ch	Id Date of Birth (DD/MM/YY)_		
Is the patient co	vered by add	itional health	n insurance	e coverage? 🗆 Yes 🗆 No If Yes:		
Other Carrier Name			_ (please include EOB of this Carrier)			
PART 3	HARMACY IN	IFORMATIO	N			
Name of Pharma	ЭСУ					
Address						
DATE RX NO. DRUG ID QTY DESCRIPTION				PRICE		
		(if given)				
			l		Total Charges	
PART 4	ECLARATION	١				
I hereby certify patient named a		e is correct a	and compl	ete and that I am claiming benefits or	nly for the charg	es for the
Primary Insured	's Signature_				Date	

Coralisle Insurance (BVI) Ltd. Palm Grove House, Road Town, Tortola, British Virgin Islands PO Box 2377, Road Town, Tortola VG1110, British Virgin Islands | Tel 284 494 8450 | Fax 284 494 8559 | www.CGCoralisle.com

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