

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 _____