Prescription Drug COB Claim Form

1. Patient Information

Full Name

Date of Birth

Member ID Number

Phone Number

Address

2. Coordination of Benefits Information

Is patient covered by another health plan?

If yes, name of other insurance

Policyholder Name

Policy Number

Effective Date

Relationship to Patient

3. Prescription Drug Information

Drug Name

Strength

Quantity

Date Filled

Pharmacy Name

Pharmacy Phone

4. Payment Information

Total Drug Cost

Amount Paid by Other Plan

Amount Paid by Member

Member Signature

Date