



**PHARMACY PRESCRIPTION DRUG CLAIM FORM**

**EBD192**



PHARMACY PROVIDER NO. <sup>1</sup>

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	Date of Service	Member ID No.	Name of Patient	Prescribing Doctor's Name	Total Charge J\$	Amount Paid By Patient J\$	Signature of Person Filling Prescription	Prescription No.	Drug Details including Name of Drug, Strength, Quantity and Cost	Claim No. (Medecus' Internal Use)
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

NOTE: Claims submitted over 90 days from date of service will not be reimbursed by MedeCus.

**TOTAL**

The contents of this claim form are certified to be a true statement of professional services rendered.

Provider's Signature \_\_\_\_\_

PROVIDER NAME (printed) & STAMP <sup>2</sup> \_\_\_\_\_

Date: \_\_\_\_\_