



TIN# 100097326

**PHARMACEUTICAL CLAIM FORM (VAT INVOICE)**

<b>Name of Insured:</b>			
<b>Name of Pharmacy:</b>			
<b>Name of Patient:</b>			
<b>Address of Pharmacy:</b>			
<b>Members Identification #:</b>		<b>Pharmacy TIN #:</b>	
<b>Date of Birth:</b>	MM	DD	YY
<b>Authorization#:</b>			
<b>Name of Prescribing Doctor:</b>			
<b>Other Insurance Plan/Program Name:</b>			
<b>Name of Drug/Item &amp; Description</b>	<b>Zero Rated/Taxable</b>	<b>No. of Month's Supplied Quantity or Volume of Item/Drug</b>	<b>Charge</b>

**NOTE:**

1. Call our Health Care Coordinators for verification of benefits at 396-1303
2. The patient/member signature and date of birth are required on all claims submitted.
3. Claims must be submitted within 6 months of service date.
4. Amendments should be initialed and dated. Liquid paper will not be accepted on forms.
5. Over the counter drugs are not covered and should be paid for by patient/member.

<b>Prescription Amount:</b>	
<b>Discount:</b>	
<b>Sub-Total:</b>	
<b>VAT @7.5%:</b>	
<b>Total:</b>	
<b>Total Paid By Member:</b>	
<b>20%:</b>	
<b>Total Balance (Insurance):</b>	

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the above pharmacy for services described above.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date