FAMILY GUARDIAN INSURANCE COMPANY

Bahama Health
FEEL GOOD ABOUT YOUR HEALTHPLAN

TIN# 100097326

PHARMACEUTICAL CLAIM FORM (VAT INVOICE)

Name of Insured:			
Name of Pharmacy:			
Name of Patient:			
Address of Pharmacy:			
Member's Identification #:		**Pharmacy TIN#:**	
Date of Birth:	MM DD YYYY	**Authorization#:**	
Name of Prescribing Doctor:			
Other Insurance Plan/Program Name:			

Name of Drug/ Item & Description	Zero Rated/Taxable	No. of Month's Supplied Quarterly or Volume of Item/Drug	Charge

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.**

Prescription Amount:	
Discount:	
Sub-Total:	
VAT @12%	
Total:	
Total Paid By Member:	
20%:	
Total Balance (Insurance):	

I certify that the above information and services provided are true and correct.

_____ _____

Provider's Signature Date

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