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:** | | | |
| **Date of Service:** | | | |
| **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 |
|---|---|---|---|
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**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.**

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|---|---|
| **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