PRESCRIPTION DRUG CLAIM FORM

PLEASE COMPLETE ONE CLAIM FORM PER PATIENT

Please complete an "Other Insurance and Dependent Coverage Questionnaire" at least once per year

Employee Information: Complete all sections.				
Employer Information	Name of Your Employer			Group Number
Employee Information Check box if new address. ☐	Employee's Last Name	First Name	Initial	Employees Social Security No. - -
	Home Address			
	City	State	Zip	Daytime Phone Number

Prescription Drugs: Please attach the Prescription drug receipt for all charges.			
Name of Patient	Date of Purchase	Name of Pharmacy	Amount of Prescription
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
		TOTAL	$

Employee Certification: Employee signature required.	
I verify the above information is true and accurate.	
Employee's Signature	Date Month / Day / Year

Please send the completed claim form and appropriate statements to:

TRISTAR Benefit Administrators

P.O. Box 65887, Des Moines, IA 50265

Ph: 800-456-4584; Fax: 515-453-8210