BROADREACH MEDICAL RESOURCES
1350 BROADWAY, STE 410
NEW YORK, NY 10018

Prescription Drug Claim Form

Cardholder Name: _____ (First) _____ (Middle) _____ (Last)

Cardholder ID Number: _____

Cardholder Address: _____ (Street)

_____ (City) _____ (State) _____ (ZIP)

Employer Name: _____

Patient's Name: _____ (First) _____ (Middle) _____ (Last)

If your medication is covered under ANY OTHER insurance plan, provide the name of the Employer and Insurance Company: _____
_____

Note: If the primary Insurance Company does not pay a pharmacy benefit, an Explanation of Benefits from the Primary Insurance Company or a print-out from the pharmacy explaining the reason for non-payment should be submitted with this claim form.

I certify that the above information is correct and that the person is eligible for benefit. I have received the medication described below and authorize release of all information contained on this voucher to BMR and the underwriter.

I agree that any benefit payable hereunder for prescription drugs is not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

Cardholder Signature: _____

Date: _____

Phone: _____

Attach Copies of prescription receipt showing: Pharmacy name, Prescription number, Drug name, Drug cost, Patient name, Fill date and Quantity & Days supply.