



City of Omaha Prescription Drug Claim Form

Please fill this form out in it's entirety and return to the address listed below.

COMPLETE THIS SECTION (PLEASE PRINT)	
SUBSCRIBER Name (Last Name, First Name, Middle Initial)	PATIENT Name (Last Name, First Name, Middle Initial)
SUBSCRIBER Identification Number (900XXXXXX*0X)	PATIENT Identification Number (900XXXXXX*0X)
Relationship of PATIENT to SUBSCRIBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	PATIENT Date of Birth
Do you have any other insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	PATIENT'S Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
SUBSCRIBER Mailing Address _____ _____ _____	I certify that the patient for whom this claim is made is a covered person on the CHC Nebraska City of Omaha Prescription Benefit Plan and that the prescription is for the sole use of the named patient. Signature of Subscriber or Member of Family X _____ Date _____

ATTACH ONE RECEIPT FROM THE PHARMACY

Please remember...

- Complete this form in it's entirety.
- A separate reimbursement form is required for each prescription
- Contact Customer Service with Questions (866-629-4135)

PLEASE RETURN TO:

CHC Nebraska, Inc.
PO Box 7705
London, KY 40742