



**SOMA COLLEGE HEALTH INSURANCE
PRESCRIPTION DRUG CLAIM FORM FOR PLAN 2**

Part 1 Participant Information Part 1 must be fully completed to ensure proper reimbursement for your medicine claim. Please type or print clearly	ID No.	Group Name	SOMA	
	Name	Address		
	City	State	Zip	Phone ()
	Plan Participant Information - Use a separate claim form for each family member			
	Plan Participant: <input type="checkbox"/> Male <input type="checkbox"/> Female Relationship: <input type="checkbox"/> Plan Participant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Are any of these medicines being taken for an on-the job injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Is the medicine covered under any other group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	If yes, is other coverage: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary If other coverage is primary, include the explanation of benefits (EOB) with this form.			
Name of Insurer	Policy #	ID#	Phone ()	
<p>I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to SOMA, the plan administrator, insurance underwriter, plan sponsor, policyholder and/or employer. I certify that all the information entered on this form is correct.</p>				
X _____		_____		
Signature of SOMA Member		Date		
Part 2 Important! Please remember to include all original pharmacy receipts.	You must include all original receipts with the following information: (There is a \$2,500 maximum on prescription drugs per policy year)			
	<ul style="list-style-type: none"> • Plan Participant Name • Pharmacy Name and Address or NABP Number • Prescription Number • Date Purchased • Total Charge • Medicine Strength/or NDC Number • Medicine Name • Metric Quantity, Days Supply <p>NOTE: Do not staple or tape receipts or attachments to this form.</p>			
Part 3 Mailing Address	Send This Claim Form And Original Receipts To: <p align="center">STUDENTRESOURCES P.O. BOX 809025 DALLAS, TX 75380-9025</p>			