



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

|   |  |            |              |              |
|---|--|------------|--------------|--------------|
| <p><b>Part 1<br/>Participant Information</b></p> <p>Part 1 must be fully completed to ensure proper reimbursement for your medicine claim.</p> <p>Please type or print clearly</p>  | ID No.   | Group Name | <b>SOMA</b>  |              |
|   | 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<br>Are any of these medicines being taken for an on-the job injury? <input type="checkbox"/> Yes <input type="checkbox"/> No   |            |              |              |
|   | <b>Is the medicine covered under any other group insurance?</b> <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> <p>X _____<br/>Signature of SOMA Member <span style="float:right">Date</span></p> |  |            |              |              |
| <p><b>Part 2<br/>Important!</b><br/>Please remember to include all original pharmacy receipts.</p>  | <p><b>You must include all original receipts with the following information:</b><br/>(There is a \$2,500 maximum on prescription drugs per policy year)</p> <ul style="list-style-type: none"> <li>• Plan Participant Name</li> <li>• Pharmacy Name and Address or NABP Number</li> <li>• Prescription Number</li> <li>• Date Purchased</li> <li>• Total Charge</li> <li>• Medicine Strength/or NDC Number</li> <li>• Medicine Name</li> <li>• Metric Quantity, Days Supply</li> </ul> <p><b>NOTE: Do not staple or tape receipts or attachments to this form.</b></p> |            |              |              |
| <p><b>Part 3<br/>Mailing Address</b></p>  | <p>Send This Claim Form And Original Receipts To:</p> <p align="center"><b>SUMMIT AMERICA INSURANCE SERVICES<br/>7400 COLLEGE BLVD., STE. 100<br/>OVERLAND PARK, KS 66210</b></p>  |            |              |              |