# Prescription Drug Claim Form

## University of Washington Student Plan
Underwritten by MEGA Life and Health Insurance Company

**UW HEALTH CLAIMS**
P. O. Box 34600, Seattle, WA 98124-1600
(866) 535-8503 or (206) 374-9439

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**Student Name:**

**Student Address:**

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**Social Security No.:**

**Patient Name:**

**Patient’s Relationship to Student:**

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Is the patient covered under another medical health care plan?  

- [ ] Yes
- [ ] No  

If yes, please provide the following information:

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<table>
<thead>
<tr>
<th>Company Name</th>
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**Health Care Plan's Address (PO Box or Street, City, State, ZIP)**

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<table>
<thead>
<tr>
<th>Policyholder's Name</th>
<th>Policyholder's Birth Date</th>
<th>Identification or Policy Number</th>
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</thead>
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Please read the following instructions before completing this section.

A. Use this form for **Prescription** Drugs only.

B. Use a separate form for each family member.

C. List drug purchase in date order with the oldest one first.

D. Attach copies of all drug receipts to the reverse side. Cash register receipts are not acceptable. If your pharmacy does not provide receipts, please have your pharmacist sign in the "Name of Pharmacy" column.

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<table>
<thead>
<tr>
<th>PRESCRIPTION NUMBER</th>
<th>NAME OF DRUG</th>
<th>ILLNESS</th>
<th>NAME OF PHARMACY</th>
<th>DATE OF PURCHASE</th>
<th>CHARGE</th>
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<tbody>
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I authorize all health care providers and insurance companies to release any medical or related information necessary to process this claim.

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and/or civil damages.

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**Student Signature**

**Date**