Generali Worldwide

# Health Insurance – Pharmacy Claim Form

**Please complete all sections using BLOCK CAPITALS or tick the boxes, where appropriate.**

## A. PHARMACY INFORMATION

Pharmacy Name:

Pharmacy Location:

Pharmacist: Prescribing Physician:

Benefits Verified by (if applicable):

## B. PATIENT INFORMATION

Patient Name: Member ID:

Date of Birth: M M D D Y Y

## C. SUMMARY OF PRESCRIPTION DRUG EXPENSES

| Date of Service (MM/DD/YYYY) | Prescription Number | Name of Drug | Generic | Brand | Number of Days Supplied | Quantity Dispensed | Charges |
|---|---|---|---|---|---|---|---|
| | | | ☐ | ☐ | | | |
| | | | ☐ | ☐ | | | |
| | | | ☐ | ☐ | | | |
| | | | ☐ | ☐ | | | |
| | | | ☐ | ☐ | | | |
| | | | ☐ | ☐ | | | |
| | | | ☐ | ☐ | | | |
| | | | ☐ | ☐ | | | |
| | | | ☐ | ☐ | | | |
| | | | ☐ | ☐ | | | |
| | | | ☐ | ☐ | | | |

| | |
|---|---|
| Total Charges | |
| Tax | |
| Amount Paid | |
| Outstanding Balance Due | |

Patient Account Number: Accept Assignment: ☐ Yes ☐ No

Physician/Provider ID Number:

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## D. DISCLAIMER:

**Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.**

Patient Signature:

Date: M M D D Y Y

**FAILURE TO PROVIDE COMPLETE PRESCRIPTION AND PAYMENT INFORMATION WILL RESULT IN THE DENIAL OF THE CLAIM.**

## GENERALI WORLDWIDE ASSISTANCE CENTRE

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