



**7. PRESCRIPTION DRUG CLAIMS** (Attach Itemized Pharmacy Receipt or if no itemized receipt available have your pharmacist complete this section.)

NAME OF ILLNESS OR ACCIDENT REQUIRING MEDICATION / PATIENT NAME	NAME OF DRUG AND STRENGTH	PRESCRIPTION NUMBER	DATE FILLED	NO. DAYS SUPPLY	QUANTITY PURCHASED	TOTAL COST INCL. TAX
1. PATIENT NAME:						
2. PATIENT NAME:						
3. PATIENT NAME:						
4. PATIENT NAME:						
5. PATIENT NAME:						
6. PATIENT NAME:						
7. PATIENT NAME:						
8. PATIENT NAME:						
9. PATIENT NAME:						
10. PATIENT NAME:						
11. PATIENT NAME:						
12. PATIENT NAME:						
13. PATIENT NAME:						
14. PATIENT NAME:						
15. PATIENT NAME:						
16. PATIENT NAME:						
17. PATIENT NAME:						

**TOTAL**

PHARMACY NAME: \_\_\_\_\_

PHARMACY PHONE # \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHARMACIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_