western benefits, inc.

Subscriber Services P.O. Box 22185 • Portland, Oregon 97269-2185 • 503 / 968-2360 phone • 503 / 968-2817 fax • 800 / 277-8579

MAJOR MEDICAL DRUG REPORT

Name of Subscriber (Employee) _____

Identification Number _____ Group Number _____

Home Address _____

Name of Patient _____ Date of Birth _____

Relationship to Subscriber (Employee) Self ☐ Spouse ☐ Child ☐

Only Drugs which are prescribed in writing and sold by a licensed pharmacist are covered.

- PLEASE USE A SEPARATE FORM FOR EACH MEMBER OF THE FAMILY.
- BILL OR RECEIPT MUST SHOW PATIENT'S NAME, PRESCRIPTION NUMBER, DATE, AND NAME OF DRUG.
- EACH PHARMACY BILL OR RECEIPT FOR EACH PRESCRIPTION MUST BE ITEMIZED SEPARATELY ON THIS FORM.
- ATTACH PHARMACY BILL OR RECEIPT FOR EACH PRESCRIPTION - NO CASH REGISTER RECEIPTS.
- BILLING MUST SHOW HOW MANY DAYS SUPPLY IS BEING PURCHASED.
- PRESCRIPTIONS OVER SIX MONTHS OLD WILL NOT BE ACCEPTED.

PRESCRIPTION NUMBER	PHYSICIAN	ILLNESS	DRUG STORE/ PHARMACIST	DATE OF PURCHASE	COST	DAYS SUPPLY AND QUANTITY