60 East South Temple • P.O. Box 45530
Salt Lake City, Utah 84145
Telephone (801) 578-5600 • Toll Free (800) 777-3622
Fax Number (801) 578-5903 • Web site: www.dmba.com

PRESCRIPTION CLAIM FORM

Avoid delay — answer all questions
(Instructions on back)

Insured Participant's Information and Verification — Please sign below

Participant's Name:			Birth Date:	Deseret Mutual ID Number:
Street:			I certify that this information is true and complete. I authorize Deseret Mutual, health care providers, and/or persons or entities retained by Deseret Mutual for the purpose of auditing claims to secure or release information relating to this claim. I understand, agree, and consent that this authorization shall remain in effect indefinitely. Signature:________________ Date:________________	
City:	State:	Zip Code:		
Home Telephone Number: ( )	Work Telephone Number: ( )			

Patient's Information

Patient's Name:	Relation to Insured:	Birth Date:	No. of Receipts Submitted:	Receipt Dates:

Other Insurance Information

Is the patient covered by any other group insurance, health maintenance organization (HMO), or government plan (including Medicare)? If yes, please give the following information:

Name of insurance company or other benefits provider: ________________

Insured individual's name:________________

Social Security number: ________________

Name of group policyholder and contract number:________________

Address of insurance company or other benefits provider:________________

Telephone number of insurance company or other benefits provider: ________________

HELP US PROCESS YOUR CLAIM

1. Attach complete itemized receipt(s) from the pharmacy. An itemized receipt includes:
   - Date the prescription was filled
   - Medication name and strength
   - Quantity of medication received
   - Pharmacy name and telephone number
   - Copayment amount or amount you paid for the medication
   - NDC 11 (National Drug Code) for the medication (except on foreign claims)
2. Complete and sign a prescription claim form for each patient.
3. Claims must be submitted within 15 months from the date the prescriptions were filled. Claims received after this date will not be eligible for benefits.
4. For faster processing, put receipts in date order and separate each year.
5. Send the prescription claim form and related receipts to:

Deseret Mutual
P.O. Box 45530
Salt Lake City, UT 84145

When the claim has been process, you will receive an Explanation of Benefits (EOB) from Deseret Mutual verifying payment and explaining how your claim has been handled. If you have any questions, please contact Deseret Mutual at the address above or call:

Salt Lake City, Utah. 1-801-578-5600

Toll Free. 1-800-777-3622

Hawaii 1-808-293-3970