

The Corps Network Prescription Drug Claim Form

(Contract No. GLSPW1201 through Gerber Life Insurance Company)

MEMBER INFORMATION:

Policyholder Name (Last, Middle, First) _____

Social Security Number _____ Gender Male Female

Address _____

City _____ State _____ Zip _____

Check here if this is a new address Phone Number _____ Date of Birth _____

PROCESSING INFORMATION:

Were you prescribed this medication due to an Accident? Yes No

Do you have any other insurance coverage? Yes No If you check Yes, complete the section below.

Insurance Company Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Group Number _____ ID Number _____ Effective Date _____ Termination Date _____

Claim Filing Instructions:

- ✓ Completely fill out the above information.
- ✓ Submit **Pharmacy receipt(s)** which include the following information:
 - Drug Number (NDC code)
 - Drug Name
 - Date Filled
 - Prescribing Physician
 - Dosage
 - Units

IMPORTANT: Cash register receipts will not be accepted.

You must submit the actual pharmacy receipt or a printout that includes the drug information.

You can submit your pharmacy claim by mail, e-mail or fax using the information below.

Mail This Form To:

Summit America Insurance Services
Attn: Claims Department
PO BOX 25936
Overland Park, KS 66225

E-Mail This Form To:

thecorpsnetwork@summitamerica-ins.com

Fax This Form To:

(913) 327-7520 Attn: Deb Cole

Benefits are administered by Summit America Insurance Services. Please call **(800) 301-9128** with all questions.