



# The Corps Network Prescription Drug Claim Form

(Contract No. G000181CA through Mutual of Omaha)

## 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  
7400 College Blvd. Suite 100  
Overland Park, KS 66210

### E-Mail This Form To:

thecorpsnetwork@summitamerica-ins.com

### Fax This Form To:

(913) 327-7520 Attn: TCN Claims

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