SOUTH CAROLINA PRESCRIPTION REIMBURSEMENT

Subscriber's Name: _____ Phone: _____

Subscriber's Address: _____

City & State: _____ Zip Code: _____

An individual form must be used for each family member. Please send this form with your original receipt(s) to CIGNA Insurance Services Company. Please keep a copy for your records.

Member ID _____

**** Must include Member ID of patient to process claim(s). ****

Pharmacy Name & Address	Date Filled	Name of Drug	Diagnosis Describe Illness or Injury	Prescription Charge	Prescription Number	Prescribing Physician
.						

By signing this document, I agree that the pharmacy charges listed above were in fact incurred by myself or my covered dependents under the terms of my benefit plan. I understand that the reimbursement due me will be reviewed for accuracy and I will be reimbursed only for covered prescription medication at the appropriate benefit level.

Signature of Member or Parent _____ Date _____

Mail completed form to: CIGNA Insurance Services Company, P.O. Box 190024, Charleston, SC 29419-9024

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