Tongass Timber Trust

Prescription Drug Record

PLEASE FILL IN ALL INFORMATION INDICATED. PRINT THIS FORM & ATTACH THE SMALL SLIPS OR A PRINTOUT FROM THE PHARMACY THAT INCLUDE THE SAME DATA REQUESTED BELOW.

MAIL TO:

TONGASS TIMBER TRUST
111 Stedman Street, Suite 200
Ketchikan, AK 99901

Need Help? Call us!
Telephone: 907-225-6114
Fax: 907-225-5920

Employee Name: **Employee Address:**

Employee Birth date:

Employee Phone: ( ) -

Is this claim employment related? (____Yes ____No **Employer Name / Company:**

Do you have any other health benefits for employee, spouse or child ? ____ Yes ____No

Who does it cover? **Other coverage is provided by:**

Please list the name and telephone of other coverage:

	Patient's Name	Sex	Birthday			Drug Name	Date Purchased	Nature of Illness or Injury	Amount Charged
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
								TOTAL:	

To all physicians and other health professionals, and all hospitals, other health care institutions and pharmacies: You are authorized to provide Tongass Timber Trust and any independent claims administrators and consulting health professionals and utilization review organizations with whom Tongass Timber Trust has contracted, information concerning health care, advice, treatment or supplies provided to the Patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits.

I hereby certify that the above drugs & medicines were necessary for treatment of the illness/injury reported and were purchased by me or my eligible dependants named above.

Signed: **Date:**