

PRESCRIPTION DRUG CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim

The Manhattan Life Insurance Company ManhattanLife Assurance Company of America Family Life Insurance Company
Standard Life and Casualty Insurance Company



Faster, Easier Online Claim Filing!

Through your online or mobile account, you can file your claim, check claim status, sign up for notifications, update your personal information, enroll in EFT, view your detailed policy, and more!



To receive your claim payment by Electronic Funds Transfer (EFT) please submit your claim online through your Policyholder Portal. Claim payment by Electronic Funds Transfer (EFT) may vary by product and may not be available for your plan.

Policyholder's Name

Date of Birth

Policy Number

Address

Social Security Number

Patient's Name

Please provide with this form a copy of the following:

- Detailed prescription receipt outlining what was filled
- Please complete the chart below for each prescription filled (add additional pages if necessary)

Rx (Drug) Name	Date Rx Filled	Rx Type		Amount Paid
		<input type="checkbox"/> Brand	<input type="checkbox"/> Generic	
		<input type="checkbox"/> Brand	<input type="checkbox"/> Generic	
		<input type="checkbox"/> Brand	<input type="checkbox"/> Generic	
		<input type="checkbox"/> Brand	<input type="checkbox"/> Generic	
		<input type="checkbox"/> Brand	<input type="checkbox"/> Generic	
		<input type="checkbox"/> Brand	<input type="checkbox"/> Generic	
		<input type="checkbox"/> Brand	<input type="checkbox"/> Generic	
		<input type="checkbox"/> Brand	<input type="checkbox"/> Generic	

I certify that the foregoing statements are true and correct.

Policyholder Signature

Date Signed