Healthcare Indemnity Prescription Drug Claim Form

PO Box 83043 ▪ Lincoln, NE 68501-3043 ▪ 866-863-9753 ▪ Fax: 402-479-0146

To expedite your prescription claims handling you may submit your claim over the phone by calling 866-863-9753.
To submit a Rx claim: Fax this form to 402-479-0146 or send to PO Box 83043 Lincoln, NE 68501.

Policy Number				
Policy Owner Name			SSN	
Mailing Address				
Email Address			Phone	
Date of Birth (MM/DD/YY)		Employer/Group		

PRESCRIPTION DETAILS

Patient/Insured Name (If different than owner)			
Address (If different than owner)			
Date of Birth (MM/DD/YY)		☐ Male ☐ Female	
SSN		Relationship to Policy/Certificate holder	

Prescription Name	Cost	Physician Name	Date Filled	Pharmacy Name - City and State

By signing below, I acknowledge all information I have given is true and complete to the best of my knowledge and belief.

Signature of Insured or Authorized Representative

Date of Birth (MM/DD/YY)

Please print name of Insured or Authorized Representative

If signed by Authorized Representative, describe your authority and provide documentation.
(e.g., guardian, conservator, power of attorney, etc.)