Standard Life And Casualty Insurance Company
ATTN: Claims Department
PO Box 510690
Salt Lake City, UT 84151-0690
Fax: (801) 538-0392
For information or to check claim status, call 1-800-327-0695.

HHC – PRESCRIPTION DRUG CLAIM FORM

Policyholder Information

Full Legal Name of Policyholder: _____

Policy Number: ___|___|___|___|___|___|___|___|___|___

Date of Birth: _____/_____/_____ **Phone No:** _____ - _____ - _____

Legal Residence Address: _____
Street *City* *State* *Zip*

☐ Prescription Drug Benefit Claim

Please provide with this form a copy of the following:

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

Rx (Drug) Name	Date Rx Filled	Rx Type	Amount Paid
		☐ Brand ☐ Generic	
		☐ Brand ☐ Generic	
		☐ Brand ☐ Generic	
		☐ Brand ☐ Generic	
		☐ Brand ☐ Generic	
		☐ Brand ☐ Generic	
		☐ Brand ☐ Generic	
		☐ Brand ☐ Generic	

Policyholder Signature	Date Signed

Important Information

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review. Failure to complete all sections may result in a delay in processing this claim.