HTH Worldwide Insurance Services

Mail prescription drug claims to:
HTH Worldwide Insurance Services
P.O. Box 968
Horsham, PA 19044
1.888.350.2002

PRESCRIPTION DRUG CLAIM FORM

INSTRUCTIONS:

1. Provide the PATIENT/INSURED and PRESCRIPTION Information requested below. (PLEASE PRINT—use a BLACK PEN for best quality).
2. Complete a separate claim form for **each patient.**
3. The **original paid pharmacy receipts** showing prescription detail **must be taped to the form.** A cash register receipt is **not** satisfactory evidence of purchase. If you have more than two receipts for the same patient, use another form.
4. Remember to sign the form and enter the total amount of your receipts in the space provided.
5. Mail your prescription drug claims to the address above and keep a copy for your records.

INSURED'S INFORMATION

Patient's Full Name	Insured's ID#	Insured's Full Name (if not patient)		
Mailing address of insured	City	State	ZIP Code	Patient's Date of Birth
I certify that the patient for whom this is made is a covered person in this prescription drug program and that the prescription is for the sole use of the named patient. (Insured/Authorized Representative) X		TOTAL AMOUNT $		

PRESCRIPTION (Rx) INFORMATION

Each prescription submitted for reimbursement MUST include the drug quantity, drug name and strength. Be sure to **tape** the original paid pharmacy receipt(s) to the form and enter the total of both drug receipts in the space marked "TOTAL AMOUNT."

TAPE original pharmacy receipt with prescription detail HERE

TAPE original pharmacy receipt with prescription detail HERE