**IPM Health & Welfare Trust of California**



**1168 E La Cadena Drive, Riverside, CA 92507**

## Tel: (951) 684-1791

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| PRESCRIPTION CLAIM ***(ONE FORM PER PATIENT)*** | | | | |
| Member’s Name: | | SS# \_\_ \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | | |
| Employer: | | | | |
| Member’s Address: | | | | |
| City: | | | State: | Zip: |
| Patient’s Name: | SS# | | | Relationship: |
| I authorize any pharmacy or physician to disclose the drug and quantity of the prescription to IPM Health & Welfare Trust.  Signature: Date: | | | | |

All receipts for this patient should be attached below. Your claim cannot be processed without the ***cash register receipt***, and the receipt showing the date filled; prescription number; national drug code; manufacturer; quantity; number of days supply; amount charged.