HRA –Reimbursement Request for Prescriptions

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(Company Name)

Employee Name: _______________________

Patient Name: _______________________

Today's Date: _______________________

Attach prescription tickets below. In order to receive an HRA Reimbursement for this prescription, a copy of the prescription ticket (showing prescription **name** and **price**) must be presented. Purchase receipts are optional.

Use a separate sheet for each Insured Member.

Attach Prescription Labels Here

Patient:
Address:

Prescription Name ⇩

Date: 09/22/09 Rx: 6903066

Drug: MICROGESTIN FE1.5/3 TAB WATS Quantity: 28

52544-0631-28

PAI UHEALTH 01 01/31/74

Patient Instructions:
>6903066 MICROGESTIN FE1.5/3 TAB WATS
-Follow dosing directions very carefully.
-Consult patient-package information
-Report difficulty with contact lenses to Dr
-Do not use if pregnant or while breast-feeding.
-Check with Dr. before taking any other medicine
-Promptly report unusual symptoms/effects to Dr
-Smoking not recommended with estrogen therapy
-Tell doctor your complete medical history

CALL YOUR DOCTOR FOR MEDICAL ADVICE ABOUT SIDE EFFECTS.
YOU MAY REPORT SIDE EFFECTS TO FDA AT 1-800-FDA-1088.
6903066 Store ID: 1245285865

MICROGESTIN FE1.5/3 TAB WATS
THIS MEDICINE IS A(N) MULTI-COLOR
(2) ROUND-SHAPED TABLET IMPRINTED
WITH WATSON 631 OR WATSON 632.
ADD INFO: 21 GREEN (631), 7 BROWN
(632)

6903066-52544063128

#28 $30.99

Prescription Price ⇧

SAMPLE

Fax / Mail / Email Completed form to:

Averill Anderson, LLC
316 S. Main Street
West Bend, WI 53095
Fax: 1-800-861-8741
Email: hra@averillanderson.com

For office use only: