Agent:________________ **Sav-Rx** Date:________________

1-800-228-3108 Phone 1-888-810-1394 Fax

Eligibility Amendment Form

Call is From: ☐ Patient ☐ Pharmacy

Pharmacy Phone# ______________________ Contact Name ________________

Action Requested:

- ☐ Add Member Coverage
- ☐ Change Information
- ☐ Add Dependent Coverage
- ☐ Request Card

Cardholder Information:

Cardholder Name: ____________________________________Group #: ____________
Cardholder Id#: _____________________________Phone# (____) __________________
Address: ____________________________________D.O.B.: _______________________
City: ________________________________State: ________________Zip: ___________

Dependent Information:

Name _____________________________ **M** ☐ **F** ☐ **D.O.B** __________________
Name _____________________________ **M** ☐ **F** ☐ **D.O.B** __________________
Name _____________________________ **M** ☐ **F** ☐ **D.O.B** __________________
Name _____________________________ **M** ☐ **F** ☐ **D.O.B** __________________
Name _____________________________ **M** ☐ **F** ☐ **D.O.B** __________________

Client Information:

Eligibility Start Date _____________ Eligibility End Date _____________

Authorized By: ____________________________