Hillsboro City Schools Prescription Cover Sheet

Only use this form if insurance is **NOT** being used at the pharmacy.

Employee Name: ______________________________

Patient Name: ________________________________

Member ID Number (on ID card): __________________

Prescription receipt **must** include drug name, patient name, date filled, and amount paid.

Please submit detailed prescription receipts to CareFactor.

CareFactor
Attention: Jill Wilson or Melissa Skaggs
PO Box 9057
Dublin, OH 43017

4789 Rings Road • Dublin, OH 43017 • 614.766.5800 • FAX 614.766.1007 • www.mycarefactor.com