Mail To:
ABA, Inc.
P. O. Box 10787
Burbank, CA 91510
(818) 842-0147

PRESCRIPTION DRUG STATEMENT

NAME OF EMPLOYEE	SOCIAL SECURITY NUMBER
NAME OF PATIENT	CALENDAR YEAR
EMPLOYER NAME	GROUP #

PLEASE COMPLETE AND ATTACH DRUG BILLS

PRESCRIPTION NUMBER	DATE OF PURCHASE	HOW MANY DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN	NAME OF DRUG OR MEDICATION	AMOUNT CHARGED

EMPLOYEE'S SIGNATURE	DATE