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

PRESCRIPTION DRUG STATEMENT

NAME OF EMPLOYEE	EMPLOYEE I.D. NUMBER
NAME OF PATIENT	CALENDAR YEAR
NAME OF EMPLOYER	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	TELEPHONE NO.	DATE