



**Tri-State Business
Group on Health**
8437 Bell Oaks Drive, PMB #126
Newburgh, IN 47630

Invoice No. RXSAVINGS

Invoice

Member

Name _____
Address _____
City _____ State _____ Zip _____

Date

Qty	Description	Amount	Total
1	Caremark Prescription Savings Card Cardmember Social Security Number: _____ - _____ - _____ Last Name _____ Street Address _____ City _____ State _____ Zip _____ Phone () _____ - _____ 01 Cardmember First Name, Birthday, Sex (M/F): _____ 02 Spouse First Name, Birthday, Sex (M/F): _____ 03 Dependent First Name, Birthday, Sex (M/F): _____ 04 Dependent First Name, Birthday, Sex (M/F): _____ 05 Dependent First Name, Birthday, Sex (M/F): _____ <i>Please make check payable to: TSBGH</i>	\$24.00	\$24.00

Payment Details

- Checks Only
- Payable Upon Receipt

Thank You!

Subtotal	\$24.00
Tax	\$0.00
Shipping	\$0.00
Total	\$24.00