Gallagher | STUDENT HEALTH & SPECIAL RISK

Prescription Override Form

If you are traveling abroad and need to fill multiple months of a prescription prior to your departure, you must submit this Prescription Override Form to Gallagher Student Health & Special Risk.

Please allow **at least 2 business days** for processing. Contact Gallagher Student Health at 877-320-4347 with any questions.

1. **Student Name:** _____ **Student ID #**_____

   School Name: _____

   Student Phone #: _____
   (best telephone number to reach you)

   Student Email: _____

2. **International Destination:** _____
   You must attached proof of your departure (i.e. ticket or travel itinerary)

3. **Departure Date:** _____

   Return Date: _____

4. **Requested number of months of prescription (Cannot exceed plan termination date):** _____
   If the number of months requested extends beyond the plan's termination date, Gallagher Student Health will need to confirm and update student's eligibility prior to processing override. If not, students will need to pay for prescriptions and seek reimbursement.

5. **Name and dose of prescription #1:**_____
   Please check one of the following (please select only one)**:** ❍ **Generic** ❍ **Brand name**

   Name and dose of prescription #2:_____
   Please check one of the following (please select only one)**:** ❍ **Generic** ❍ **Brand name**

7. **Requested pick-up date (Cannot be more than 2 weeks prior to departure date):** _____
   This Prescription Override expires within 48 hours of the requested pick-up date.

8. **Name of Pharmacy:** _____

9. **Pharmacy Phone Number:** _____

Once complete, submit this form to Gallagher Student Health in one of the following ways:
E-Mail to: PrescriptionAssistance@gallagherstudent.com
Fax to: 617-479-0860 Attn: Prescription Assistance

Internal Use Only:
Date Received:
Date Processed: Processed by: