



## 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](mailto:PrescriptionAssistance@gallagherstudent.com)

**Fax to:** 617-479-0860 **Attn:** Prescription Assistance

**Internal Use Only:**

Date Received:

Date Processed:

Processed by: