Prescription Drug Rebate Program Benefit Summary

Date: [Insert Date]

Recipient Name: [Insert Recipient Name]

Recipient Address: [Insert Recipient Address]

Dear [Recipient Name],

We are pleased to provide you with a summary of your benefits under the Prescription Drug Rebate Program. This program is designed to help you save on your prescription medications.

Program Benefits

- Discount on branded medications: [Insert Percentage or Dollar Amount]
- Generic drug pricing: [Insert Percentage or Dollar Amount]
- Co-payment assistance: [Insert Details]
- Additional savings on specialty drugs: [Insert Details]

Eligibility Requirements

To qualify for the rebate program, you must:

- Be a member of [Insert Program Name]
- Provide documentation of your prescription purchases
- Meet the income criteria for assistance

Contact Information

If you have any questions regarding your benefits or need assistance, please contact us at:

Phone: [Insert Phone Number]

Email: [Insert Email Address]

Thank you for being a valued member of our program. We are committed to helping you manage your prescription costs.

Sincerely,

[Your Name]

[Your Title]

[Organization Name]