Please read REVERSE SIDE before completing this form: YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.

PLEASE PRINT

Plan Member Name:				. 1 11				
	First		М	iddle		Last		
atient Name:First		Middle			Last			
				Pat	ient's Date of F	Birth:/	/	
Plan Member ID Number		Patient Code	Group Nu		on but of E	, <u></u> -		
Plan Member Address:								
	Street			City		State	ZIP	
Employer Name:	oyer Name:			Insurance Company:				
Patient: Sex: M F (Circle One)								
I certify that the above information is co- contained on this voucher to MaxorPlus		checked person is eligi	ble for benefits. I ha	ve received the medi	cation described he	reon and authorize releas	se of all information	
I agree that any benefits payable hereun no assignment of benefits hereunder.	der for prescription drug	,				•		
		Plan M	ember Signatu	re:				
Is this medication covered und	der any other grou	p insurance plan?	YES	_ NO	_ If YES: WI	HO?:		
Please ask your pharmacis (You may attach a co						SS THIS FORM IS ains all of the necessary		
Rx Number	Date Fille	ed	Quantity		_ Days Supply	Rx Price		
Medication Name				Dosage Form		Strength		
NDC No		Doctor's DEA #		Doctor's l				
Rx Number	Date Fille	ed	Quantity		_ Days Supply	Rx Price		
Medication Name				Dosage Form		Strength		
NDC No		Doctor's DEA #		Doctor's Name				
Rx Number	Date Fille	ed	Quantity		_ Days Supply	Rx Price		
Medication Name				Dosage Form		Strength		
NDC No.		Doctor's DEA #		Doctor	's Name			
Rx Number	Date Fille	ed	Quantity		_ Days Supply	Rx Price		
Medication Name				Dosage Form		Strength		
NDC No.		Doctor's DEA #		Doctor	's Name			
REASON FOR MANUAL (CLAIM							
PLACE PHARMACY LABEL HERI	E OR ENTER							
DI AV		()		=			
Pharmacy Name			Phone					
Street Address			NABP	#				
City Sta	ate ZIP		Pharmacist Si	gnature	=			

MAXORPLUS PRESCRIPTION DRUG CLAIM FORM

Please Read Carefully Before Completing This Form

Use this claim form to request reimbursement for prescription drugs purchased:

* In emergency situations when a non-participating pharmacy is utilized.

When filling out claim forms:

- * Complete a separate form for each family member for whom prescription drugs were purchased.
- * Complete a separate form for each pharmacy where prescription drugs were purchased.
- * Complete the top portion of the form in full. Incomplete forms will be returned to you for completion.
- * Include these numbers from your prescription card:
 - -Plan member's (insured) social security number/ID number
 - -Patient code two-digit number assigned to individual family member (listed on card)
- * Attach a copy of your prescription receipt to the lower portion OR give to your pharmacist to complete.

FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

Patient Reimbursement Claims
MAXORPLUS
320 S. Polk, Suite 200
Amarillo, Texas 79101