

MaxorPlus Prescription Drug Claim Reimbursement Form

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

Plan Member Name _____
First
Middle
Last

Patient Name _____
First
Middle
Last

Plan Member ID Number _____ Patient Code _____ Group Number _____ Patient's Date of Birth

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 Patient: Sex M F
(Circle One)

Plan Member Address _____
Street
City
State
Zip

Employer Name _____ Insurance Company _____

I certify that the above information is correct and that the above checked person is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this voucher to MaxorPlus and the underwriter.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

 Plan Member Signature

Is this medication covered under any other group insurance plan? YES _____ NO _____ If YES: WHO? _____

Please ask your pharmacist to complete the remaining portion: YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE
 (You must attach a copy of the prescription receipts.)

Rx Number:	Rx Number:	Rx Number:
Date Filled:	Date Filled:	Date Filled:
Quantity:	Quantity:	Quantity:
Days Supply:	Days Supply:	Days Supply:
Rx Price:	Rx Price:	Rx Price:
Medication Name:	Medication Name:	Medication Name:
Dosage Form:	Dosage Form:	Dosage Form:
Strength:	Strength:	Strength:
NDC No.:	NDC No.:	NDC No.:
Doctor's DEA #:	Doctor's DEA #:	Doctor's DEA #:
Doctor's Name:	Doctor's Name:	Doctor's Name:

REASON FOR MANUAL CLAIM: _____

PLACE PHARMACY LABEL HERE OR ENTER:

Pharmacy Name _____
 Street Address _____
 City _____ State _____ Zip _____

Area Code - Phone Number _____
 NABP# _____
 Pharmacist Signature _____

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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) 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.

If you have any questions, Please call: MaxorPlus Customer Service at (888) 839-4448.



FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

Patient Reimbursement Claims

MAXORPLUS

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