MaxorPlus Prescription Drug Claim Reimbursement 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) 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 (800) 687-0707.

FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

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Patient Reimbursement Claims

MAXORPLUS

320 S. Polk, Suite 200
Amarillo, Texas 79101

Maxor
PHARMACY BENEFIT MANAGEMENT SERVICES

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 mm dd yyyy Patient: Sex M F (Check 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 may attach a copy of the prescription receipts as an alternative to completing the information below, as long as it contains all of the necessary information)

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 ____ Area Code - Phone Number ____

Street Address ____ NABP# ____

City State Zip ____ Pharmacist Signature ____