

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

PLEASE PRINT

Plan Member Name: _____
First Middle Last

Patient Name: _____
First Middle Last

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

Plan Member Address: _____
Street City State ZIP

Employer Name: _____ Insurance Company: _____

Patient: Sex: M F
(Circle One)

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

Rx Number _____ Date Filled _____ Quantity _____ Days Supply _____ Rx Price _____
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REASON FOR MANUAL CLAIM _____

PLACE PHARMACY LABEL HERE OR ENTER

Pharmacy Name _____ () Phone _____

Street Address _____ NABP # _____

City _____ State _____ ZIP _____ Pharmacist Signature _____

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.

If you have any questions, please call: MAXORPLUS Customer Service at (800) 687-0707.

FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

Patient Reimbursement Claims
MAXORPLUS
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Amarillo, Texas 79101