

PRESCRIPTION CLAIM FORM - DIRECT MEMBER REIMBURSEMENT

YOU WILL RECEIVE REIMBURSEMENT FOR THIS CLAIM AT THE ALLOWED AMOUNT (LESS THE COPAYMENT)

- Keep a copy of all documents submitted for your records.
- Reimbursement is not guaranteed, and is subject to limitations, exclusions and provisions of the plan.
- Please allow up to 30 days from the time you send this form until the time you receive the response
- Please attach receipts, labels, and/or a printout from the pharmacy for verification

1. Member Information: This section must be fully completed to ensure proper reimbursement of your claim.

Member ID Number (refer to your benefits card)			
Name (Last)		(First)	(MI)
Address			
Address 2			
City		State	Zip Code
Date of Birth		Male	Female
/ /		Phone Number	
Relationship:	Employee	Spouse	Child
Other:			

2. PLEASE ASK THE PHARMACIST TO COMPLETE THE PORTION BELOW.

PHARMACIST: A UNIVERSAL CLAIM FORM MAY BE ATTACHED IN PLACE OF FILLING OUT THE FORM.

Date Filled	Rx Number	Quantity	Day Supply	NDC Number
/ /				- - - - -
Drug Name, Strength, Dosage Form		Prescriber's Name:		
Total Rx Price (including tax)		Prescriber's NPI or DEA#		
\$				
Pharmacy Name: NPI or NABP:				
Pharmacy's Phone Number: ()				
Pharmacist's Signature				

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

X _____
Signature of Member Date



MAIL: MAXCARE P.O. BOX 16430 OKLAHOMA CITY, OK 73113

FAX: 405-213-1521