

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		N 4: al al a		Lot		
	First		Middle	Patient's Date	Last		
Plan Member ID Number	Patient Code	Group Nu	mber	of Birth	mm dd yyyy Pat	tient: Sex M F (Circle One)	
Dia a Maracha a Addasa							
Plan Member Address	Street		City		State	Zip	
Employer Name					Insurance Company		
					s. I have received the medication de	escribed hereon and	
authorize release of all information					gnment or attempted assignment t	thoroof chall he word	
I further represent that there ha				and that any assi	griment of attempted assignment t	inereor shall be volu	
					Plan Member Signature		
Is this medication covered unde	r any other group ins	urance plan? YES	NO	If YES: WHO	?		
	,						
Please ask your pha	rmacist to complete t				ROCESSED UNLESS THIS FORM IS C	OMPLETE	
		(You <u>must</u> attach a co	opy of the pre	escription 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		Area Code - Phone Number					
Street Address			NABP#				
City State Zip	0		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 (800) 687-0707.



FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

Patient Reimbursement Claims

MAXORPLUS

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