



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

\_\_\_\_\_  
Employer Name Insurance Company

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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:

Area Code - Phone Number

NABP# \_\_\_\_\_

Pharmacist Signature \_\_\_\_\_

# 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**

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