

# 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  
(Circle 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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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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