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

320 S. Polk, Suite 200

Amarillo, Texas 79101

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

________________ ________ ____________ Patient's Date of Birth: _______/_______/_______
Plan Member ID Number Patient Code Group Number

Plan Member Address: ____
Street City State ZIP

Employer Name: ______________________ Insurance Company: ______________________

Patient: Sex: M F
(Select 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 __________
Medication Name ______________________ Dosage Form __________ Strength __________
NDC No. ______________ Doctor's DEA # ______________ Doctor's Name ______________

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 __________
Medication Name ______________________ Dosage Form __________ Strength __________
NDC No. ______________ Doctor's DEA # ______________ Doctor's Name ______________

REASON FOR MANUAL CLAIM____

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PLACE PHARMACY LABEL HERE OR ENTER

______________________ (________)______________
Pharmacy Name Phone

______________________ ______________________
Street Address NABP #

______________________ ______________________
City State ZIP Pharmacist Signature