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

__________________ Plan Member ID Number
__________ Patient Code
__________________ Group Number
Patient's Date of Birth: ______/______/______

Plan Member Address: ____
Street City State ZIP

Employer Name: ______________________________ Insurance Company: ______________________________

Patient: Sex: M F
(Circle 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____

____

____

PLACE PHARMACY LABEL HERE OR ENTER

______________________________ Pharmacy Name
(__________)______________________ Phone

______________________________ Street Address
______________________ NABP #

______________________________ City State ZIP
______________________ Pharmacist Signature

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