Maxor™
PHARMACY BENEFIT MANAGEMENT SERVICES

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

_____ _____ _____ Patient's Date of Birth ☐☐ ☐☐ ☐☐☐☐ Patient: Sex M F
Plan Member ID Number Patient Code Group Number mm dd yyyy (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 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:

_____ _____
Pharmacy Name Area Code - Phone Number

_____ _____
Street Address NABP#

_____ _____
City State Zip 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.

Maxor

PHARMACY BENEFIT MANAGEMENT SERVICES

FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

Patient Reimbursement Claims

MAXORPLUS

320 S. Polk, Suite 200
Amarillo, Texas 79101