PRESCRIPTION CLAIM FORM - DIRECT MEMBER REIMBURSEMENT

YOU WILL RECEIVE REIMBURSEMENT FOR THIS CLAIM AT THE ALLOWED AMOUNT (LESS THE COPAYMENT)

- **Keep a copy of all documents submitted for your records.**
- **Reimbursement is not guaranteed, and is subject to limitations, exclusions and provisions of the plan.**
- **Please allow up to 30 days from the time you send this form until the time you receive the response**
- **If you are submitting multiple claims; only one form is necessary.**
- **Please attach receipts, labels, and/or a printout from the pharmacy for verification**

1. Member Information: This section must be fully completed to ensure proper reimbursement of your claim.

Member ID Number (refer to your benefits card)				
Name (Last)	(First)		(MI)	
Address				
Address 2				
City	State		Zip Code	
Date of Birth / /	Male ☐	Female ☐	Phone Number	
Relationship:	Employee ☐	Spouse ☐	Child ☐	Other: ☐

2. PLEASE ASK THE PHARMACIST TO COMPLETE THE PORTION BELOW.
PHARMACIST: A UNIVERSAL CLAIM FORM MAY BE ATTACHED IN PLACE OF FILLING OUT THE FORM.

Date Filled	Rx Number	Quantity	Day Supply	NDC Number
_____/_____/_____	_____	_____	_____	
Drug Name, Strength, Dosage Form		Prescriber's Name:		
Total Rx Price (including tax) $		Prescriber's NPI or DEA#		

Pharmacy Name:_____ NPI or NABP: _____

Pharmacy's Phone Number: ( ) _____

Pharmacist's Signature _____

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

X_____

Signature of Member **Date**

MAXCARE Rx

MAIL: MAXCARE; P.O. BOX 16430 OKLAHOMA CITY, OK 73113 FAX: 405-213-1521