PRESCRIPTION CLAIM FORM - DIRECT MEMBER REIMBURSEMENT

USE ONLY WHEN A PRESCRIPTION IS FILLED OUT OF NETWORK

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

PLAN NAME:_____ **PLAN NUMBER:**_____

FOR INFORMATION NECESSARY TO COMPLETE THIS FORM, PLEASE REFER TO YOUR I.D. CARD.

Cardholder Name (Employee): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Group Number: _____ Cardholder's Identification Number: _____

Patient Code: _____ Patient Name: _____

Sex: [] Male [] Female Patient Date of Birth: _____

Signature: _____ Telephone Number: (_____) _____

PLEASE ASK THE PHARMACIST TO COMPLETE THE PORTION BELOW:

PHARMACIST: A completed Universal Claim Form may be attached in place of filling out the form below.

Date Filled mm/dd/yy	Rx No.	[] New [] Refill	Metric Quantity	Days Supply	National Drug Code Number
____/_____/____	_____		_____	_____	__ __ __ __ __ - __ __ __ __ - __ __

Drug Name, Strength, Dosage Form	Medical Doctor Name (or) DEA Prescriber #	Total Rx Price (Including Tax)	(FOR OFFICE USE ONLY)
_____ _____ _____	_____	$_____	

Date Filled mm/dd/yy	Rx No.	[] New [] Refill	Metric Quantity	Days Supply	National Drug Code Number
____/_____/____	_____		_____	_____	__ __ __ __ __ - __ __ __ __ - __ __

Drug Name, Strength, Dosage Form	Medical Doctor Name (or) DEA Prescriber #	Total Rx Price (Including Tax)	(FOR OFFICE USE ONLY)
_____ _____ _____	_____	$_____	

_____ (_____)_____ _____

PHARMACY NAME PHONE NUMBER NABP #

PHARMACIST SIGNATURE: _____ DATE: _____

MAIL FORM TO: MAXCARE; P.O. BOX 18204; OKLAHOMA CITY, OK 73154