

Member Prescription Reimbursement Claim Form

MEMBER SECTION Please submit one form for each person

Client Name: Maricopa County

Client Number: 2229

Employee Name: _____

Employee ID Number: _____ - _____ - _____
(9 digit ID - copy exactly from WHI ID card)

Employee Address: _____

City: _____

State: _____

ZIP: _____ - _____

PATIENT SECTION Please submit one form for each person

Name of Covered Person: _____

Relationship: spouse dependent self

Birth Date: _____ - _____ - _____
month day year

Sex: Male Female

Request Reason: _____

I certify that the attached prescription(s) have been received and information stated is accurate. I also authorize the release of all information contained herein to Walgreens Health Initiatives and its agents. I understand that all prescription receipts must be submitted within 180 days of prescription receipt date in order to be processed and considered for reimbursement.

Employee Signature

Date

**Please complete Pharmacy Section on the back of this form and mail to:
Maricopa County Benefits Office
301 West Jefferson, Suite 201
Phoenix, AZ 85003**

PHARMACY SECTION Please submit one form for each person

Attach the original prescription sheet to this form. Keep a copy for your records. Reimbursement is based on your plan's maximum benefit. Incomplete information may delay processing or may cause this form to be returned. (If you need assistance in filling out this information, please refer to your prescription receipt or contact the pharmacy in which the medication was dispensed.)

Pharmacy NABP # (7 digits)	RX#	Fill Date	Total Paid	Quantity	Days Supply	DRUG NDC # (11 digits)	Prescriber Name

INTERNAL USE ONLY	
<p>_____ Maricopa County Benefits Office Authorized Signature</p>	<p>_____ Date</p>
<p><input type="checkbox"/> In-Network Reimbursement</p>	<p><input type="checkbox"/> Out of Network Reimbursement</p>
<p><input type="checkbox"/> Approved</p>	<p><input type="checkbox"/> Denied</p>