Pharmacy Reimbursement Request

Mail to: **Maxor Pharmacies**
1046-B Hercules Ave., Houston, TX 77058

Patient Name:_____
First Middle Last

Address:

_____
Street City State Zip

Member I. D. #_____Member's Date of Birth _____

Reason for Request::_____

_____

_____

A pharmacy receipt must be attached that includes the following information or the pharmacist must complete and sign the following form.

Pharmacy_____Address_____Phone_____

Rx Number _____ Date filled _____Quantity____Price_____Day Supply____

Drug Name_____NDC Number _____

Doctor Name_____

Pharmacy_____Address_____Phone_____

Rx Number _____ Date filled _____Quantity____Price_____Day Supply____

Drug Name_____NDC Number

_____

Doctor Name_____

Pharmacy_____Address_____Phone_____

___

Rx Number _____ Date filled _____Quantity____Price_____Day

Supply____

Drug Name_____NDC Number

_____

Doctor Name_____

I certify that the above information is correct and the above person is eligible for benefits.

Member

signature_____

I certify that the above information is correct and the amount paid is accurate.

Pharmacist

signature_____NABP#_____