PRESCRIPTION BENEFIT CLAIM FORM

MEMBER'S NAME: _____

MEMBER'S ID #: _____

MEMBER'S ADDRESS: _____

_____

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PLEASE ATTACH <u>DETAILED</u> RECEIPT(S). For OTC products, receipts must identify the item(s), quantity purchased, amount paid, and date of purchase.

<u>SEND COMPLETED FORM TO:</u>
NORTHWEST PHARMACY SERVICES
2479 GRIFFIN AVE, SUITE 102
ENUMCLAW, WA 98022
<u>OR</u>
SEND VIA SECURE FAX TO: 360-802-5116