

# 20 Authorization to Reimburse Prescription Expenses Under the Negotiated Contract 2009-2010

Date: \_\_\_\_\_ Name: \_\_\_\_\_

First \$100 out-of-pocket costs expended. Yes \_\_\_\_\_ No \_\_\_\_\_  
(Please provide documentation with first request)

Family Member \_\_\_\_\_

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Family Member \_\_\_\_\_

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Family Member \_\_\_\_\_

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Family Member \_\_\_\_\_

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Date: \_\_\_\_\_ Presc# \_\_\_\_\_ Amount Paid \_\_\_\_\_ Reimbursed \_\_\_\_\_  
(For Office Use)

Pharmacy documentation must be attached indicating date, name of patient, prescription number and amount paid.

**TOTAL REIMBURSED** \_\_\_\_\_

**Requested by:** \_\_\_\_\_

**Authorized by:** \_\_\_\_\_