PRESCRIPTION CLAIM FORM

MEMBER'S NAME: _____

MEMBER'S ID #: _____

MEMBER'S ADDRESS: _____

_____

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PLEASE ATTACH DETAILED PRESCRIPTION RECEIPT(S) HERE

SEND COMPLETED FORM TO:
NORTHWEST PHARMACY SERVICES
2479 GRIFFIN AVE, SUITE 102
ENUMCLAW, WA 98022