**SAMISH INDIAN NATION**



**TEMPORARY PRESCRIPTION REIMBURSEMENT CLAIM FORM**

**PRESCRIPTION
REIMBURSEMENT
 CLAIM FORM**

DATE SUBMITTED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT INFORMATION:

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE\_\_\_\_\_\_ ZIP CODE\_\_\_\_\_

PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SAMISH PRC ID/6-DIGIT CHART # \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

MAIL THIS FORM AND PRESCRIPTION RECEIPT TO:

SAMISH PURCHASED/REFERRED CARE
PO BOX 2702
PORTLAND, OR 97208-2702

PHONE (360) 899-5454