SAMISH INDIAN NATION

**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 CHART # \_\_ \_\_ \_\_ \_\_ \_\_ ENROLLMENT #\_\_ \_\_ \_\_ \_\_

MAIL THIS FORM AND PRESCRIPTION RECEIPT TO:

SAMISH PURCHASED/REFERRED CARE
PO BOX 217
ANACORTES, WA 98221

PHONE (360) 899-5454