DRUG REIMBURSEMENT FORM

(Reimbursement For Secondary Coverage Under OEA Choice Trust)

______________________________ ID# __ __ __ - __ __ - __ __ __ __
Member Name

____
Member Address City State Zip

______________________________ ______________________________
Patient Name Date of Birth

______________________________ ID# __ __ __ - __ __ - __ __ __ __
Primary Carrier

____
Signature

	Date of Service	Name of Medication	Amount You Paid Pharmacy
Rx #1.			
Rx #2.			
Rx #3.			
Rx #4.			
Rx #5.			

Please complete and submit this form along with your prescription receipts for Co-pay reimbursement to:

OEA Choice Trust
Claims Department
PO Box 23600
Tigard OR 97281-3600

(800) 452-0914
Fax # (503) 624-3994