



## Pharmacy Reimbursement Claim Form

### Biographical Information

First and Middle Name: \_\_\_\_\_

Last Name (surname): \_\_\_\_\_

Insurance ID number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### Contact Information

#### United States Address

Street: \_\_\_\_\_ Apt#: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Pharmacy Information

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

Street: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please:

- 1) Complete this form.
- 2) Submit copies of the original pharmacy receipt(s), including physician name, name of medication, charge, etc. for processing.

**3) Mail your form and receipt(s) to:      **The Lewer Agency, Inc.****

**P.O. Box 32247**

**Kansas City, MO 64171-5247**

**or** submit to front desk and we will process for you.