

**CHELAN COUNTY REIMBURSEMENT CLAIM FORM**  
**LEOFF I – PRESCRIPTION DRUG CO-PAYMENTS and MEDICAL EXPENSES**

Claimant: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

City

State

Zip

ATTACH COPIES OF “EXPLANATION OF BENEFIT” &/OR PRESCRIPTION CO-PAY RECEIPTS FOR REIMBURSEMENT

Date	Location/ Prescription No.	Prescription Name/ Description of Medical Treatment	Amount
<b>TOTAL AMOUNT DUE TO CLAIMANT</b>			

I hereby certify under penalty of perjury that this is a true and correct claim for reimbursement of prescription co-payments incurred by me, and that no payment has been or is eligible to be received by me on account thereof from any other source.

Sign Here \_\_\_\_\_  
 (Claimant)

Send this form, with Prescription Co-pay Receipts AND/ OR “Explanation of Benefits” to:  
 Chelan County Commissioners; Attn: Katie Batson; 400 Douglas Street, Suite #201; Wenatchee, Washington 98801