# 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 RECIEPTS FOR REIMBURSEMENT

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| --- | --- | --- | --- |
| **Date** | **Location/ Prescription No.** | **Prescription Name/ Description of Medical Treatment** | **Amount** |
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|  |  | **TOTAL AMOUNT DUE TO CLAIMANT** |  |

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: Rosalinda Barragan; 400 Douglas Street, Suite #201; Wenatchee, Washington 98801