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

Date	Location/ Prescription No.	Prescription Name/ Description of Medical Treatment	Amount
		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)
Phone Number ________________________

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