BAY CITIES BROKERAGE

ALL FIELDS ARE REQUIRED

Member's Name: _____

Member's Date of Birth: _____

Medicaid ID Number: _____

Authorized Party (Printed): _____ Authorizing Signature: _____

Appointment Office Address: _____

Patient's Appointment Time: _____ Completed Time: _____

Appointment Reason Circle One: Routine Follow-Up Pharmacy Appointment Date: _____

ALL REIMBURSEMENT REQUESTS MUST HAVE PRIOR AUTHORIZATION | OAR 410-136-3240

Additional Information: For out of town appointments members MUST schedule at least 2 business days in advance or the request will not be authorized - Copies of this **blank** form is allowed.

Upon Completion, please return the **original** slip via mail to Bay Cities Brokerage - 3505 Ocean Blvd SE, Coos Bay, OR 97420 or you can drop it off at 1290 NE Cedar St, Roseburg, OR 97470 | Any reimbursement requests that are received after 45 days from the appointment will not be accepted | Upon receipt please allow 30 days for processing - Thank You.

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