*ALL FIELDS ARE REQUIRED* FACILITY STAMPS ARE ACCEPTED

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:_______________ Miles Traveled: ___________

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

ALL REIMBURSEMENT REQUESTS MUST HAVE PRIOR
AUTHORIZATION | OAR 410-136-3240 | **To obtain authorization please call 1-877-324-8109**

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 are allowed.

Upon Completion, please return the **original** slip via mail or drop off to Bay Cities Brokerage - 3505 Ocean Blvd SE, Coos Bay 97420 | Any reimbursement requests that are received after 45 days from the appointment will not be accepted | Upon receipt please allow 30 days for processing, and if you have any questions please call 1-877-324-8109

**TRIPS TO THE EMERGENCY ROOM ARE NOT AUTHORIZED**

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