SAMISH INDIAN NATION

PRESCRIPTION REIMBURSEMENT CLAIM FORM

DATE SUBMITTED _____

PATIENT INFORMATION:

NAME_____

DATE OF BIRTH_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

PHONE NUMBER_____

SAMISH CHART # _____ ENROLLMENT #_____

MAIL THIS FORM AND PRESCRIPTION RECEIPT
WITHIN 90 DAYS OF PURCHASE TO:

SAMISH PURCHASED/REFERRED CARE
PO BOX 217
ANACORTES, WA 98221

PHONE (360) 899-5454