SAMISH INDIAN NATION

PRESCRIPTION CLAIM FORM

DATE SUBMITTED _____

PATIENT INFORMATION

NAME _____

DATE OF BIRTH _____

STREET ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

PHONE NUMBER _____

SOCIAL SECURITY NUMBER _____

MAIL THIS FORM AND RECEIPTS TO:

NORTHWEST PHARMACY SERVICES
2479 GRIFFIN AVENUE #102
ENUMCLAW, WA 98022

PHONE (800) 998-2611