

Medication Extended Day Supply Request Form

Section 1: Traveling Member's Information

First Name:	<input type="text"/>		
Middle Initial:	<input type="text"/>		
Last Name:	<input type="text"/>		
Policy ID Number:	<input type="text"/>	Date of Birth:	<input type="text"/>
E-mail Address:	<input type="text"/>		
Phone Number:	<input type="text"/>		

Section 2: Travel Information

Destination(s):	<input type="text"/>		
Travel Reason:	<input type="text"/>		
Departure Date:	<input type="text"/>	Return Date:	<input type="text"/>
		Months Away:	<input type="text"/>

The Plan reserves the right to request additional supporting travel documentation, such as international visas, itineraries, or airline tickets, if deemed necessary.

Section 3: Medication Information

Medication Names, Quantity, Dosage, and Strength:	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>

Section 4: Signature

No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the State Treasurer or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan or in any representation or attestation to the Plan. I certify that I (or my eligible dependent) have read and understood this form, and that all the information entered on this form is true and correct.

X	<input type="text"/>
	Signature of Plan Participant/Legal Guardian/Power of Attorney (REQUIRED)
	<input type="text"/>
	Relationship to recipient of the extended day supply of medication

For Office Use Only:

Approve:	<input type="text"/>	Deny:	<input type="text"/>	Reviewed By:	<input type="text"/>
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