North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Medication Extended Day Supply Request Form

Section 1: Traveling Member's Information

First Name:

Middle Initial:

Last Name:

Policy ID Number:

Date of Birth:

E-mail Address:

Phone Number:

Section 2: Travel Information

Destination(s):

Travel Reason:

Departure Date:

Return Date:

Months Away:

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:

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

Signature of Plan Participant/Legal Guardian/Power of Attorney (REQUIRED)

Relationship to recipient of the extended day supply of medication

For Office Use Only:

Approve: *Deny:* *Reviewed By:*

Information contained in this form constitutes Protected Health Information (PHI) that should be protected from unauthorized access. This form should not be emailed without being encrypted. If your system does not support email encryption, it is advisable to contact SHPEDSR@nctreasurer.com for information on how this form can be emailed securely to the State Health Plan.