

# 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:	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" 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**   
 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: