



**MUNICIPALITY OF MONROEVILLE**  
**PRESCRIPTION REIMBURSEMENT**  
**FORM**



Submittal Date \_\_\_\_\_ Home Department \_\_\_\_\_

Please send check to (please print)

NAME \_\_\_\_\_ Phone \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE \_\_\_\_\_

Signature \_\_\_\_\_ DATE \_\_\_\_\_

PRESCRIPTION NUMBER	PRESCRIPTION NAME	Reimbursement Requested	MAINTENANCE DRUG	Generic Or Brand Name
			YES or NO	GEN or BRAND
			YES or NO	GEN or BRAND
			YES or NO	GEN or BRAND
			YES or NO	GEN or BRAND
			YES or NO	GEN or BRAND
			YES or NO	GEN or BRAND
			YES or NO	GEN or BRAND
			YES or NO	GEN or BRAND
			YES or NO	GEN or BRAND
			YES or NO	GEN or BRAND
Amount due from MUNICIPALITY		\$		

Use back of sheet for any additional information.

**ATTACH ALL ORIGINAL PRESCRIPTION RECEIPTS FOR EXPENSES LISTED ABOVE. RETURN TO THE FINANCE AND PERSONNEL OFFICE BEFORE THE 20<sup>TH</sup> OF EACH MONTH SO A CHECK MAY BE ISSUED ON THE SECOND TUESDAY OF EVERY MONTH AFTER THE COUNCIL MEETING. (For MEDCOHEALTH prescriptions, please submit the entire page of the Home Delivery Pharmacy statement. All original documents will be returned to you when your check is processed.**