LIPITOR CO-PAY REIMBURSEMENT FORM

Name: ________________________________ **Phone #:** ____________________

Address: ________________________________ **E-Mail:** ____________________

Pharmacy: ________________________________

Date of Purchase: ______________

AMOUNT OF REIMBURSEMENT: **$**_________________

Doctor: ________________________________

Active Employee: _________ **Retiree:** _________

Department: ________________________________

Employee #: ________________________________

Signature: ____ **Date:** ____________

FOR OFFICE USE ONLY

Approval for reimbursement: ____
E. Susan Ellis, Personnel Director

Account #: _____________________________