



MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lieutenant Governor

DAVID R. BRINKLEY
Secretary

MARC L. NICOLE
Deputy Secretary

OUT-OF-COUNTRY PRESCRIPTION DRUG REQUEST FORM

PLEASE COMPLETE THIS FORM
For Yourself and/or Your Covered Dependent(s) and return it to:

Employee Benefits Division
Attention: Customer Service Unit
301 W. Preston Street, Room 510
Baltimore, Maryland 21201
410.333.7104 (Fax)

I, _____, will be out-of-the country
(Name)
for _____ months on work-related business/study abroad program/Fulbright scholar.
(Number)

I am writing to the State of Maryland requesting approval for an early re-fill of the prescription medication(s) listed below. Supporting documentation confirming my destination, departure and return dates is attached. (Form will not be processed without supporting documentation.)

Employee/Retiree/Dependent Name: _____

Current Telephone Number(s): _____

Departure Date: _____

Return Date: _____

Overseas Address:

Medication(s) Requested: _____

Prescribing Physician's Name: _____ Telephone #: _____

Employee/Retiree/Dependent's Signature _____ Date _____

Employee/Retiree Social Security # _____ Date _____

DBM Employee Benefits Director's Signature _____ Date _____