



# Maryland

DEPARTMENT OF BUDGET  
AND MANAGEMENT

WES MOORE  
Governor

HELENE GRADY  
Secretary

ARUNA MILLER  
Lieutenant Governor

MARC L. NICOLE  
Deputy Secretary

## OUT OF COUNTRY EARLY REFILL PRESCRIPTION DRUG REQUEST FORM

Complete this form for yourself and/or your covered dependents

**BEFORE SUBMITTING THIS FORM**, please confirm the following:

- Request is at least 2 weeks in advance of your departure date
- Scheduled for a minimum period of no less than 30 consecutive days out of the country and a maximum approval of a 90 day supply of medication.
- Confirmed there are no outstanding premiums during time of request
- Attach supporting documentation confirming destination, departure/return dates and reason for travel. If return date is not yet determined, documentation provided should show support for return date not being provided.
- One request form per member/dependent needing an early refill.

**Once completed, return to:** Employee Benefits Division,  
301 W. Preston St., Rm 510 Baltimore, Md 21201

or

**Email to:** [EBD.Mail@Maryland.gov](mailto:EBD.Mail@Maryland.gov) or **Fax:** 410.333.5191

I, \_\_\_\_\_ will be out of the country  
(Name of Person Traveling)

For \_\_\_\_\_ months on work-related business/study abroad program/Fulbright scholar/vacation.

Employee/Retiree/Dependent name: \_\_\_\_\_

Current Telephone Number(s): \_\_\_\_\_

Departure Date: \_\_\_\_\_ Return Date: \_\_\_\_\_

Overseas Address: \_\_\_\_\_

\_\_\_\_\_

Medication Requested: \_\_\_\_\_

\_\_\_\_\_

Prescribing Physicians Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Employee/Retiree/Dependent Signature

Employee/Retiree W# or Social Security Number: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

DBM Employee Benefit's Director's Signature

Rev 1/06/2025

301 W. Preston Street • Baltimore, MD 21201

Tel: 410-767-4715 • Fax: 410-333-5262 • Toll Free: 1-800-705-3493 • TTY Users: Call via Maryland Relay

<http://dbm.maryland.gov>