KENTUCKY PUBLIC PENSIONS AUTHORITY
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Print Form

Form 8040
Revised 11/2023

Prescription and Nonprescription Medications

Member Information

Member Name:		Member ID:	
Address:	City:	State:	Zip Code:
Phone (select type) ☐ Mobile ☐ Home ☐ Work	Email:		

Prescription Medications

Medicine Name	Dosage	Times/Day	Reason for Medicine	Prescribing Physician

Nonprescription Medications

Medicine Name	Dosage	Times/Day	Reason for Medicine	Prescribing Physician

I hereby certify that the information provided on this form is correct and accurate. I acknowledge that I have full understanding that any person who provides a false statement, report, or representation to a governmental entity such as KPPA is subject to the penalty of perjury in accordance with KRS 523.010, et seq. I further acknowledge that if I knowingly submit or cause to be submitted a false or fraudulent claim for the payment or receipt of benefit, I may be liable for repayment of benefits I was not entitled to receive, but also liable for civil payments, legal fees, and costs.

Signature: _____ Date: _____