

# PRESCRIPTION CLAIM FORM

MAIL CLAIMS TO:  
 253 West 35<sup>th</sup> Street □ 12<sup>th</sup> floor □ NEW YORK, NEW YORK 10001  
 (212) 505-5050

CLAIM #
RETURNED FOR:

MEMBER: FIRST	MIDDLE	LAST	DATE EMPLOYED
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MEMBER: MAILING ADDRESS	Number and Street	Apt	SOCIAL SECURITY #
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HOME PHONE:	( ) -
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CITY	STATE	ZIP	WORK PHONE:
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DATE PURCHASED	FIRST NAME PATIENT	RELATIONSHIP	PRESCRIPTION NO.	NAME OF PHARMACY	NAME OF DRUG	NAME OF DOCTOR	COST	CO-PAY AMOUNT
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**PHARMACY DRUG PRINTOUTS MAY BE USED IN LIEU OF FILLING OUT INDIVIDUAL PRESCRIPTION LINES PROVIDING THAT THE PATIENT'S NAME, DATE OF PURCHASE, PRESCRIPTION NUMBER, NAME OF DRUG, PRESCRIBING DOCTOR'S NAME, DISPENSING PHARMACY AND THE COST OF THE PRESCRIPTION TO THE PATIENT IS ENTERED. MAXIMUM BENEFIT \$100 PER CALENDAR YEAR PER FAMILY**

IF MORE SPACE IS NEEDED, ATTACH AN ADDITIONAL CLAIM FORM.

TOTAL AMOUNT MUST BE ENTERED TO RECEIVE PAYMENT. \$ \_\_\_\_\_

I CERTIFY THAT THE ABOVE CHARGES WERE FOR THE BENEFIT OF MY ELIGIBLE FAMILY MEMBERS LISTED. I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING THESE PRESCRIPTIONS TO THE BENEFIT FUND OR THEIR REPRESENTATIVES FOR PURPOSE OF AUDIT OR VERIFICATION.

MEMBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## PRESCRIPTION DRUG BENEFIT

### WHO IS ELIGIBLE...

Member claiming for self and/or dependents

### WHAT IS THE BENEFIT...

Once annually, up to a maximum of \$200 per family, the Fund reimburses to a member the co-payment costs which have been paid within the calendar year for drugs prescribed by a medical doctor, osteopath or dentist. Prescription must be dispensed by a licensed pharmacist.

Prescription services which are covered are those eligible under your primary prescription plan.

### RESTRICTIONS...

- Only one claim per year is eligible.
- Individual prescriptions not accompanied by a pharmacy printout or copy of receipt. Do not submit original receipts. (The Fund is not responsible for loss if originals are submitted.)
- The Fund prescription drug coverage is secondary to your primary prescription drug coverage.

### CLAIMING...

The entire form must be completed in order to be eligible for payment. HOWEVER, PHARMACY DRUG PRINTOUTS MAY BE USED IN LIEU OF FILLING OUT INDIVIDUAL PRESCRIPTION LINES PROVIDING THAT THE PATIENT'S NAME, DATE OF PURCHASE, PRESCRIPTION NUMBER, NAME OF DRUG, PRESCRIBING DOCTOR'S NAME, DISPENSING PHARMACY AND THE COST OF THE PRESCRIPTION TO THE PATIENT IS ENTERED. THE CO-PAYMENT AMOUNT MUST BE INDICATED EITHER ON THE CLAIM FORM OR THE PHARMACY'S PRINT-OUT. All claim forms MUST contain a total dollar amount on line 25 or the claim will be returned to you without payment. All items listed will be subject to verification.

Your prescription drug claim MUST be submitted in the first quarter following the year charges were made in order to be eligible for coverage. (Example: Covered expenses incurred from 1/1/99 through 12/31/99 can be claimed between 1/1/00 and 3/31/00).

### PRESCRIPTION DRUG CLAIM MAY ONLY BE SUBMITTED ONCE ANNUALLY

### NOTE...

The same rules and regulations governing your primary prescription drug plan apply. The Fund does not cover prescription costs incurred by members beyond the amount payable by your primary prescription drug plan. If for some reason you had to pay full price for a prescription (perhaps your card was unavailable, or you were out-of-state), you MUST first submit the costs to your primary prescription plan prior to claiming. Do not submit your claim to the Fund unless all costs are backed by proof. Submissions at a later date will NOT be reconsidered for payment.

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**"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD THE FUND OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACTUAL MATERIAL THERETO, COMMITS A FRAUD, WHICH IS A CRIME."**

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