



PRESCRIPTION CLAIM FORM

MAIL CLAIMS TO:
253 West 35th St., New York, NY 10001 12th Floor
(212) 505-5050 ext. 229

CLAIM #
RETURNED FOR

MEMBER: FIRST	MIDDLE	LAST	DATE EMPLOYED
MEMBER: MAILING ADDRESS		MEMBER SOCIAL SECURITY NO.	
CITY, STATE, ZIP		HEALTH PLAN COVERAGE	
HOME PHONE	WORK PHONE	<input type="checkbox"/> GHI <input type="checkbox"/> HMO Print name of present HMO	
		<input type="checkbox"/> OTHER Spouse's Coverage	

DATE PURCHASED	FIRST NAME PATIENT	RELATIONSHIP	PRESCRIPTION NO.	NAME OF PHARMACY	NAME OF DRUG	NAME OF DOCTOR	COST	CO-PAY AMOUNT
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
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16								
17								
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22								
23								
24								
25								

PHARMACY DRUG PRINTOUTS MAY BE USED IN LIEU OF FILLING OUT INDIVIDUAL PERSCRIPTION 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.

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 PURPOSES OF AUDIT OR VERIFICATION.

MEMBER SIGNATURE _____ DATE _____

PREScription DRUG BENEFIT

WHO IS ELIGIBLE...

Member claiming for self and/or eligible dependents

WHAT IS THE BENEFIT...

Once annually, up to a maximum of \$300 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. Prescriptions must be dispensed by a licensed pharmacist.

Prescription services which are covered include:

- Prescriptions which require compounding;
- Prescriptions for legend drugs (drugs which cannot be dispensed by a pharmacist without a prescription);
- Insulin on prescription;
- Allergenic solutions or extracts normally purchased at a pharmacy and authorized by a doctor;
- Prescribed vitamins;
- Prescribed birth control drugs.

DESCRIPTION OF BENEFIT...

Active member and retiree benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees.

RESTRICTIONS...

- Only one claim per family, 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. (Example: GHI, HMO or spouse's coverage)
- No coverage is provided for over-the-counter drugs, vitamins, diet supplements, etc., which even though prescribed by physician, can be legally purchased without a prescription.
- Allergy prescriptions unable to be filled at a licensed pharmacy.
- Drugs prescribed for cosmetic purposes.

CLAIMING...

Obtain a prescription drug claim form from your department's fund office. 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 claims forms **MUST** contain a total dollar amount on line 31, or the claim will be returned to you without payment. All items listed will be subject to verification.

Submit your completed and signed form only after you have accumulated a minimum annual total of \$300 for prescription drugs. If you do not meet the minimum prior to the end of the year, submit your claim for whatever the amount below that figure after the last day of the calendar year. In order to be eligible for coverage, your prescription drug claim **MUST** be submitted no later than December 31st of the year following the year charges were incurred. (Example: Covered expenses incurred from 1/1/99 through 12/31/99 must be claimed by 12/31/2000)

PREScription DRUG CLAIM MAY ONLY BE SUBMITTED ONCE ANNUALLY

NOTE

The same rules and regulations governing New York City 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.

"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."