Prescription Claim Form

Suffolk County Municipal Employees Benefit Fund
30 Orville Drive, Suite D
Bohemia, New York 11716
(631) 319- 4099

Refer to Filing Instructions Before Completing
Please Contact the Fund for Maximum Reimbursement Amounts
One Claim Per Family Per Year Accepted

ADMINISTRATIVE USE ONLY

CLAIM #

EMPLOYEE: LAST FIRST	EMPLOYEE SOCIAL SECURITY # OR PIN #
ADDRESS	DEPARTMENT
CITY STATE ZIP	OFFICE PHONE
HEALTH COVERAGE PLAN	HOME PHONE

	PATIENT NAME	PHARMACY	$ TOTAL PRINTOUTS FOR PATIENT
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
	AMOUNT REIMBURSED BY ALTERNATE CO-PAYMENT INSURER (Attach Statement From Other Insurer)		
		TOTAL	

Co-payments Reimbursed By Any Other Insurer MUST Be Listed

I certify that the above charges were for the benefit of my eligible family members and that I/we have not been reimbursed for these expenses from any other source. I authorize the release of any information concerning the prescriptions to the Benefit Fund or their representatives for the purpose of verification. I further certify that I have submitted **ALL EXPENSES** for reimbursement and waive right to any additional benefit for the year being filed.

EMPLOYEE SIGNATURE **DATE**

PRESCRIPTION DRUG CO-PAYMENT CLAIM FORM INSTRUCTIONS

Filings are limited to one (1) claim per family, per calendar year.
Please contact the Fund for the maximum reimbursement amounts.

PLEASE READ CAREFULLY BEFORE COMPLETING THIS CLAIM FORM

PROOF OF PAYMENT MUST BE ATTACHED. INDIVIDUAL RECEIPTS MUST BE ACCOMPANIED BY SCHEDULE A.

PHARMACY PRINTOUT FILINGS:

Complete this form for all persons covered under the insured's benefit. Prescriptions for a member, spouse, duly enrolled domestic partner and covered child should be on the same form. Identify each family member and list all printouts for that person, including the total of each one. Do this for each individual you are submitting for. Please complete all required areas of information.
Do not forget to sign and date the bottom of the form.

HEALTH CARE PRINTOUT:

Complete all required areas of information on this form and attach the health care printout you receive annually from your health coverage. All the information requested on this form is contained on your printout.

INDIVIDUAL RECEIPTS:

Individual receipts **will not** be accepted as proof of payment unless the pharmacy utilized can not produce a printout. Schedule A must be attached to this completed claim form when submitting individual receipts. Complete Schedule A as follows:

a. Prescription co-payments must be listed in date order by patient.
b. Attach clear COPIES of individual receipts. (ORIGINAL receipts will be returned to you.)
c. Receipts must be copied in the same order as listed on Schedule A and must contain the corresponding line number from the claim form.
d. Altered receipts will be disallowed unless signed by the pharmacist.

WHO IS ELIGIBLE:

Member, spouse, duly enrolled domestic partner, unmarried dependent children to age 19 and unmarried dependent FULL-TIME students to age 25.

1. This form is to be used for claiming the Prescription Drug Co-payment Benefit provided to eligible Suffolk County Municipal Employees Benefit Fund members and their dependents for prescription drug co-payments paid out-of-pocket during each calendar year.

2. Please contact the Fund for the maximum allowable co-payment. Expenses covered by the Fund and not covered by "the plan" shall not be paid in excess of "the plan's" established co-payment. All rules and regulations governing "the plan" apply to your Fund coverage.

3. Claims for prescription drug co-payments can only be filed **ONCE** annually. Submit only after you have accumulated the maximum allowable total for co-payment costs. If you do not meet the maximum total prior to the end of the year, submit your claim for whatever the amount below that figure after the last day of that calendar year. Any claim paid by the Fund will NOT be reconsidered at a later date.

COVERED EXPENSES:

1. Prescriptions which require compounding.
2. Prescription for LEGEND DRUGS (drugs which can not be dispensed without a prescription).
3. All other drugs covered by "the plan" in accordance with the terms and conditions set forth by "the plan."

EXCLUSIONS:

1. No coverage is provided for OTC (over-the-counter) drugs, vitamins, diet supplements, etc., which even though prescribed by a physician can be legally purchased without a prescription.
2. Drugs covered by this plan must be prescribed by a licensed medical doctor, osteopathic physician or dentist.
3. All drugs must be dispensed by a registered pharmacy.
4. Drugs which are administered to in-patients of any hospital are not eligible.
5. Single prescriptions which exceed a 3-month supply. (This does not apply to refills which are obtained at a later date.)
6. Growth stimulating drugs, food supplements, cosmetic drugs, or any other drug prescribed for conditions other than injury, illness, or disease are not covered by the plan.
7. Expenses not submitted prior to December 31st of the current year for the previous year will not be eligible for reimbursement. Example: Claims for 2009 must be received/postmarked by 12/31/10.
8. If prescription co-payments are reimbursable under Workers' Compensation, these co-payments are not eligible for Fund reimbursement.