Prescription Drug Co-Payment Reimbursement Claim Form

FOR ADMINISTRATIVE USE ONLY

Suffolk County Municipal Employees Benefit Fund
30 Orville Drive, Suite D
Bohemia, New York 11716-2513
(631) 319-4099 www.scmebf.org

MEMBER: LAST	FIRST	MEMBER ID (BF#) BF00
MAILING ADDRESS		DEPARTMENT
CITY	STATE ZIP	OFFICE PHONE / HOME PHONE
EMAIL ADDRESS		CELL PHONE

Refer to Filing Instructions On Reverse Side Before Completing. One Claim Accepted Per Family Per Year.

1. This form is to be used for claiming the Prescription Drug Co-Payment Reimbursement Benefit provided to eligible Suffolk County Municipal Employees Benefit Fund members and their eligible dependents for prescription drug co-payments up to $400 each calendar year PLUS up to $1.00 additional Co-Pay Reimbursement for each Prescription Co-pay over $400, **all by prescription date-fill order.**

2. The maximum allowable drug reimbursement is $25 per script, **in date-fill order**. Expenses covered by the Fund and not covered by the "health plan" shall not be paid in excess of the "health plan's" established drug co-payment. All rules and regulations governing the "health plan" apply to your Fund coverage.

3. Claims for prescription drug co-payments only can be filed **ONCE** annually. **Submit ONLY after you have accumulated all your drug co-payment costs for the entire year.** If filed before the end of the year and before you complete your prescription co-payments, any claim paid by the Fund at that time will **NOT** be reconsidered at a later date. **Additional reimbursement requested by a member who previously filed a claim, which was previously processed and paid, will be rejected!**

	PATIENT NAME	AMOUNT
1		
2		
3		
4		
5		
6		

Do You Get Reimbursed by An Alternate Insurance Plan? ☐ **Yes** ☐ **No** **Subtotal:**

If Yes, List Alternate Insurer: ____________________ **Amount Reimbursed:**

(Attach Statement From Alternate Insurance) **TOTAL:**

Member MUST Enter Amount of Drug Co-Payments Reimbursed by Any Other Plan!

I certify the above charges were for the benefit of my eligible family members and I/we have not been reimbursed for these expenses from any other source. I authorize the release of any information pertaining to these prescriptions to the Benefit Fund or their representatives for the purpose of verification. **I FURTHER CERTIFY I HAVE SUBMITTED ALL EXPENSES FOR REIMBURSEMENT FOR THE YEAR FILED AND WAIVE THE RIGHT TO ANY ADDITIONAL BENEFIT!**

______________________________ MEMBER SIGNATURE

______________________________ DATE

PRESCRIPTION DRUG CO-PAYMENT REIMBURSEMENT CLAIM FORM INSTRUCTIONS
Filing is limited to one (1) claim per family, per calendar year.

PLEASE READ CAREFULLY BEFORE COMPLETING THIS CLAIM FORM.
PROOF OF PAYMENT MUST BE ATTACHED.

PHARMACY PRINTOUT FILINGS: Complete this form for all persons covered under the member's benefit. Prescriptions for a member, spouse or eligible domestic partner and covered children (see definitions below) must be listed on the same form. Identify each family member and submit all printouts for each person, including the total for each one. Be certain to do this for each individual listed on the claim form. Please complete all required areas of information. **Please remember to sign and date the bottom of the form**.

HEALTH CARE PLAN PRINTOUT: Complete all required areas of information on this form and attach the annual health care printout you receive from your prescription drug/health plan coverage (Example: if enrolled in EMHP, submit the annual statement you receive from the prescription plan manager.) All the information required on this form is contained on your printout. You can also **contact Express Scripts at 1-800-987-5242.**

INDIVIDUAL RECEIPTS: **Individual receipts will no longer be accepted as proof of payment!**

WHO IS ELIGIBLE:
Member, spouse, duly enrolled domestic partner, unmarried dependent children to age 19, unmarried dependent FULL-TIME students to age 26 and unmarried children, regardless of age, incapable of self-sustaining employment by reason of mental or physical disability acquired before the termination of eligibility twenty six {26} and reside with and wholly depend upon the covered member for support.)

THE PRESCRIPTION DRUG CO-PAYMENT REIMBURSEMENT BENEFIT – effective January 1, 2020:
1. This form is to be used for claiming the Prescription Drug Co-Payment Reimbursement Benefit provided to eligible Suffolk County Municipal Employees Benefit Fund members and their eligible dependents for prescription drug co-payments up to $400 each calendar year PLUS up to $1.00 additional Co-Pay Reimbursement for each Prescription Co-pay over $400, **all by prescription date-fill order.**

2. The maximum allowable reimbursement is $25 per script, **in date-fill order**. 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 all your co-payment costs for the entire year.** If filed before the end of the year and before you complete your prescription co-payments, any claim paid by the Fund at that time will **NOT** be reconsidered at a later date. **Additional reimbursement requests by a member who previously filed a claim, which was processed and paid, will be rejected!**

COVERED EXPENSES:
1. Prescriptions which require compounding.
2. Prescription for LEGEND DRUGS (drugs which cannot be dispensed without a prescription).
3. All other drugs covered by your health plan in accordance with the terms and conditions set forth by that plan.

EXCLUSIONS:
1. No coverage is provided for medical supplies or equipment, 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 administered to patients in a hospital setting are not eligible.
5. Single drug prescriptions exceeding a 3-month supply. This does not apply to refills 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 are not eligible for co-payment reimbursement. Example: **CLAIMS FOR 2023 EXPENSES MUST BE RECEIVED/POSTMARKED BY 12/31/24**!
8. Prescription drug co-payments that are reimbursable under workers' compensation are not eligible for Fund reimbursement.

6/24/24