INSTRUCTIONS

- Use a separate form for each patient
- Include all original pharmacy receipts with prescription detail clearly noted which must include the name, strength, quantity and price. PLEASE ATTACH TO THIS FORM
- Receipts must be mailed within 90 days from date of service
- Reimbursement will be in accordance with a Schedule of Allowances
- Incomplete forms will be returned for additional information without payment
- Cash register receipts or credit/debit card receipts are not valid for processing
- Retain a copy of this submission for your own records
- Benefits are payable directly to the CARDHOLDER and are NOT ASSIGNABLE to pharmacies or other insurance/health/benefit plans
- Mail to the address shown at the left side of the form: ATTN: PHARMACY PROGRAM

Claim Receipts

Review the following information for each prescription:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and day's supply
- Prescription number (Rx number)
- Amount paid

CASH REGISTER RECEIPTS OR CREDIT/DEBIT CARD RECEIPTS ARE NOT VALID FOR PROCESSING

IMPORTANT: I certify that the patient information entered on this form is correct, that the patient named is eligible for the benefits, and if between the ages of 19-23, is an unmarried full-time student, and that the medication(s) have been received.

I agree that the benefits payable for prescription drugs are not assignable and that any assignment or attempted assignment shall be void.

I also authorize release of all information pertaining to this claim to MEDCO, the UFT Welfare Fund and to any insurance company or other payment organization.
**PHARMACY INFORMATION (FOR COMPOUND PRESCRIPTIONS ONLY)**

This section to be completed by Pharmacist only

<table>
<thead>
<tr>
<th>RX #</th>
<th>Date Filled</th>
<th>Days Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL QUANTITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL CHARGE</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INSTRUCTIONS FOR PHARMACIST:**

- List the valid 11 digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the “metric” quantity expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipts must be attached to claim form.

**COORDINATION OF BENEFITS**

**RULES AND INSTRUCTIONS:**

- If your spouse/domestic partner is covered under another prescription drug plan, that plan must be used prior to submitting for reimbursement to the Welfare Fund.
- Attach receipts of his/her co-payment or other out-of-pocket co-insurance below.
- Reimbursement will be a Schedule of Allowances over the applicable UFT Welfare Fund co-payments.
- Computer printouts, computerized paid receipts from pharmacies, direct reimbursement forms showing proof or other carrier payment, or other similarly marked receipts will be accepted.

ATTACH RECEIPTS, PRINTOUTS, ETC. TO TOP OF PAGE