UFT
WELFARE FUND
52 BROADWAY
7TH FLOOR
NEW YORK, NY 10004
212-539-0500

Prescription Drug Reimbursement Form

FOR IN-SERVICE MEMBERS

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

Member/Subscriber Information

Member ID: _____
(See your prescription drug ID card)
or Social Sec. No.: ___ – ___ – _____

Member Name (First, Last)

Street Address

City State Zip

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year) ☐☐ ☐☐ ☐☐☐☐

Sex
☐ Female
☐ Male

Relationship to Plan Member
☐ Self ☐ Spouse ☐ Eligible Child ☐ Dependent Student ☐ Disabled Dependent ☐ Dependent Parent ☐ Domestic Partner ☐ Other

Claim Receipts

Tape receipts or itemized bills below and on back.

Check the appropriate box if any receipts or bills are for:

❑ **Coordination of benefits with other insurance/ health/benefit plan.**
See instructions on back.

❑ **Compound prescription**
Make sure your pharmacist lists ALL the VALID NDC numbers and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

❑ **Medication purchased outside of the United States**
Please indicate:
Country _____
Currency used _____

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on the back.

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- 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

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- 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

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.

Signature _____ Date _____

(Over)

Claim Receipts Please tape additional receipts here. **Do not staple!**

Tape receipt for prescription 3 here.

Receipts must contain the following information:

- 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

Tape receipt for prescription 4 here.

Receipts must contain the following information:

- 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

PHARMACY INFORMATION (FOR COMPOUND PRESCRIPTIONS ONLY)

This section to be completed by Pharmacist only

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

RX # 1		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity
TOTAL QUANTITY	
TOTAL CHARGE	

RX # 2		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity
TOTAL QUANTITY	
TOTAL CHARGE	

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