



Prescription Drug Co-Pay Reimbursement Claim Form

(STATE EMPLOYEES)

(800) 323-2732

Claim Form must be completed and signed by the CSEA Employee Benefit Fund Member. All required documentation must be attached. INCOMPLETE CLAIMS WILL BE RETURNED.

Mail completed claims to:
CSEA Employee Benefit Fund
P.O. Box 516
Latham, New York 12110-0516

Claim year you are submitting for: _____

Last First M.I. EBF ID #

Member's mailing address: Apt. #

Member's Home Address

City: State Zip Code

Member's Home Address

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Member's Daytime Phone No. Member's Employer Member's Signature

Member's Health Insurance Carrier(s) Spouse's Health Insurance Carrier(s)

IMPORTANT - PLEASE READ

How to Claim this Benefit:

- Members who are enrolled in the New York State Health Insurance Program (either the Empire Plan or Health Maintenance Organization) are entitled to reimbursement once annually for NYSHIP prescription drug co-pays and covered prescriptions less than the co-pay for themselves and their dependents.
- Only one claim per calendar year (January – December) is processed. Once your co-pays reach \$300, the next \$100 in prescription drug co-pays is reimbursable. To obtain the maximum benefit of \$100, wait until your co-pay expenses reach \$400 before filing your claim.
- If you do not accumulate \$400 before the end of the year, submit your claim AFTER DECEMBER 31 for what you did pay over \$300. The deadline for submission is March 31 of the following year for the co-pays accumulated during the previous Calendar Year.
- Submit your completed form along with an **itemized PHARMACY PRINTOUT** clearly indicating the co-pay amount. Cash register receipts, original pharmacy receipts and cancelled checks are not acceptable. Charges for "over the counter" drugs, prescriptions not covered by your prescription plan and brand/ generic differentials are not reimbursed.