



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. Member ID Number

Number & Street Apt. No. Member's Home Address

Village/Town/City State Zip Code Member's Home Address

() - 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...
Only one claim per calendar year...
If you do not accumulate \$400 before the end of the year...
Submit your completed form along with an itemized PHARMACY PRINTOUT...