



CSEA EMPLOYEE BENEFIT FUND CLAIM FORM

PRESCRIPTION DRUG CO-PAY

PHYSICIAN CO-PAY

Claim form must be completed and signed by the CSEA Employee Benefit Fund Member. All required documentation must be attached. *Incomplete claim forms will be returned.*

Mail completed claim forms to:

CSEA Employee Benefit Fund

PO Box 516

Latham, NY 12110-0516

Member's Name: _____ EBF ID# _____

Member's mailing address: _____ Apt# _____

City: _____ State: _____ Zip code: _____

Daytime phone # () - Employer: _____

Member's Signature _____ Date ____/____/____

Member's Health Insurance Carrier(s)

Spouse's Health Insurance Carrier(s)

Please indicate which benefit you are submitting for:

Prescription Co-pay Benefit

Claim Year _____

Complete this claim form and submit with an **itemized pharmacy printout** indicating dates of service, item dispensed and co-pay amount. Please do not use highlighter on print-outs. The benefit reimburses co-pays and other out-of-pocket costs for prescription drugs which are not covered by the member's regular prescription drug plan. Please submit your claim when your yearly maximum has been reached. If you do not reach the maximum allowed under your plan, please submit your claim after December 31st for what you did pay. Deadline for submission of all claims is March 31st of the following year.

Physician Co-Pay Benefit

Claim Year _____

Complete this claim form and submit with your original receipts indicating the services and co-pay amounts of each visit. All receipts must be validated by the physician's office (professionally printed receipt or office stamp). Each receipt must include the patient's name, physician/practice name and address. Receipts must indicate the co-pay was for an *office visit*. Explanation of Benefits (EOB) from your health insurance carrier will be accepted provided that the EOB includes the necessary information needed to process your claim (Patient name, co-pay amount, date of service and indication that the service was for an *office visit*.) Please submit your claim when your yearly maximum has been reached. If you do not reach the maximum allowed under your plan, please submit your claim after December 31st for what you did pay. Deadline for submission of all claims is March 31st of the following year. **Cash register receipts, original pharmacy receipts and cancelled checks are not accepted for either of these benefits.**