Town of Ramapo Co-Pay Claim Form

Physician Co-Pay & Prescription Drug Co-Pay

CSEA EMPLOYEE BENEFIT FUND

Form must be completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached. Members are entitled to reimbursement once annually for physician visit co-pays and prescription drug co-pays for themselves and their eligible dependents. **Deadline for claim submission is March 31 of the following year.**

Claim Year _____

Member's Name _____ EBF ID# _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

Daytime Phone # _____ Email _____

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

Member's Signature _____ Date _____

Please allow up to 6 weeks for processing

PLEASE INDICATE WHICH BENEFIT YOU ARE SUBMITTING FOR

Instructions: Complete this claim form and submit with your complete itemized pharmacy printout **and/or** Explanation Of Benefits (EOB) from your health insurance carrier, when you have reached the maximum benefit for the current calendar year (January 1st - December 31st). If you do not accumulate the maximum allowed, submit your claim after December 31 for what you did pay.

$500 Prescription Drug Co-Pay Benefit: ☐ Claim Year _____

$600 Physician Co-Pay Benefit: ☐ Claim Year _____

- ***Cash register receipts, original pharmacy/physician receipts and cancelled checks are not accepted for this benefit***
- ***Please do not use highlighter on print outs***
- ***CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL***

MAIL COMPLETED FORM TO

CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12110-0516