New York State Employees
Prescription Drug Co-Pay Reimbursement Claim Form

CSEA NEW YORK Employee Benefit Fund

IMPORTANT - PLEASE READ THE FOLLOWING INFORMATION

This claim form should only be used if you are an eligible employee of New York State and in one of the following units:

Administrative Services Unit
Institutional Services Unit
Operational Services Unit
Division of Military and Naval Affairs Unit
Roswell Park

SUMMARY:

- Maximum Reimbursement per family is $400 per calendar year.
- Submit your completed form along with an **itemized pharmacy printout** clearly indicating the **patient name, co-pay amount and prescription drug names.**
- Cash register receipts, original pharmacy receipts, and cancelled checks are not acceptable.
- Charges for prescriptions not covered by your prescription plan, vaccines/injections, diabetic supplies and medical supplies/devices are not acceptable.
- Please refer to the detailed instructions on the claim form for more information.
- Please do not use highlighter on printouts.

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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 for themselves and eligible dependents.

Claim Year 2026 (January 1, 2026 to December 31, 2026)

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 _____

Deadline for claim submission is March 31, 2027

IMPORTANT — PLEASE READ

- **Only dates of service that occur between January 1, 2026 to December 31, 2026 are reimbursable.**
- Only one claim, per calendar year, per family will be processed.
- Once your co-pays reach $200, the next $400 in prescription drug co-pays is reimbursable.
- To obtain the maximum benefit of $400, wait until your co-pay expenses reach $600 before filing your claim.
- If you do not accumulate $600 before the end of the year, submit your claim **after December 31, 2026** for what you did pay over $200.
- Submit your completed form along with an **itemized pharmacy printout** clearly indicating the patient name, co-pay amount and prescription drug names. All information must be preprinted. Handwritten items are not acceptable.
- Cash register receipts, original pharmacy receipts, and cancelled checks are not acceptable.
- Charges for prescriptions not covered by your prescription plan, vaccines/injections, diabetic supplies and medical supplies/devices are not reimbursable.
- Please do not use highlighter on printouts.

MAIL COMPLETED CLAIMS TO

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

- CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL
- PLEASE ALLOW 6 WEEKS FOR PROCESSING