

# UCS Retiree Co-Pay Claim Form

## Physician Co-Pay & Prescription Drug Co-Pay



**IMPORTANT - PLEASE READ THE FOLLOWING INFORMATION**

**This benefit includes a separate Prescription Drug Co-pay and Physician Co-pay Reimbursement and this claim form should only be used if you are a Unified Court System (UCS) Retiree**

### **BENEFIT SUMMARY**

#### **Maximum Reimbursement per family:**

\$100 Prescription co-pay reimbursement, per calendar year  
\$125 Physician co-pay reimbursement, per calendar year

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(s) 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.

- **Deadline for claim submission is March 31 of the following year.**
- Pharmacy printout must indicate patient name, date of service, and name of prescription dispensed.
- Cash register receipts, original pharmacy/physicians receipts and cancelled checks are not acceptable.
- Please refer to the detailed instructions on the claim form for more information.
- Effective January 1, 2013, an Explanation of Benefits (EOB) is required for all physician claims.
- Please do not use highlighter on print-outs.

# UCS Retiree Co-Pay Claim Form

## Physician Co-Pay & Prescription Drug Co-Pay



Form must be completed and signed by the CSEA Employee Benefit Fund retiree member. All required documentation must be attached. Members are eligible for reimbursement once annually for physician office 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(S) 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(s) 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.

**\$100 Prescription Drug Co-Pay Benefit:**  Claim Year \_\_\_\_\_

Pharmacy printout must indicate patient name, date of service, and name of prescription dispensed. Only co-pays are reimbursed. Charges for non-covered drugs, items that cost less than your co-pay amount and brand/generic differentials, diabetic supplies and medical supplies/devices are not reimbursed. Please do not use highlighter on print-outs.

**\$125 Physician Co-Pay Benefit:**  Claim Year \_\_\_\_\_

Only office visit co-pays are reimbursed. Only one (1) co-pay per visit is reimbursed. Co-pays for additional services performed at the same visit are not reimbursed. **Non-physician provider, physical therapy, emergency room, hospital, urgent care, lab, x-ray/imaging and dental co-pays are not eligible. Deductible/co-insurance payments are not eligible.**

*Cash register receipts, original pharmacy/physician receipts and cancelled checks are not accepted for this benefit.*

### MAIL COMPLETED FORM TO

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