

# Local Government Co-Pay Claim Form Physician Co-Pay & Prescription Drug Co-Pay



## IMPORTANT - PLEASE READ THE FOLLOWING INFORMATION

This claim form should only be used if you are an eligible employee of one of the following units:

### An Active Employee of:

City of Long Beach  
City of New Rochelle  
Pearl River UFSD Custodians  
Smithtown Library  
Town of Babylon  
Town of Brookhaven  
Town of Clarkstown  
Town of Huntington  
Town of Smithtown  
Town of Southold  
Village of Lloyd Harbor  
Village of Southampton  
Yonkers School District

### Benefit:

Prescription Drug Co-pay only  
Prescription Drug Co-pay and Physician Co-pay  
Prescription Drug Co-pay only  
Prescription Drug Co-pay only  
Prescription Drug Co-pay and Physician Co-pay  
Prescription Drug Co-pay only  
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Prescription Drug Co-pay only  
Prescription Drug Co-pay only  
Prescription Drug Co-pay only

### A Retired Employee of:

Town of Brookhaven Full Package  
Town of Southold

### Benefit:

Prescription Drug Co-pay  
Prescription Drug Co-pay

## BENEFIT SUMMARY

Complete this claim form and submit with your 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. 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**
- 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
- An Explanation of Benefits (EOB) is required for all physician claims
- Please do not use highlighter on print-outs
- **CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL**

# Local Government Co-Pay Claim Form



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

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 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.** Submit for this benefit only if it has been negotiated for you under your collective bargaining agreement.

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 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. If you do not accumulate the maximum allowed, submit your claim after December 31 for what you did pay.

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

Reimburses co-pays and other out-of-pocket costs for prescription drugs which are not covered by the member's regular prescription drug plan.

**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 receipts/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**

***CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL***