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

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 one of the following units:

An Active Employee of:	**Benefit:**
City of Long Beach	Prescription Drug Co-pay only
City of New Rochelle	Prescription Drug Co-pay and Physician Co-pay
Pearl River UFSD Custodians	Prescription Drug Co-pay only
Smithtown Library	Prescription Drug Co-pay only
Town of Babylon	Prescription Drug Co-pay and Physician Co-pay
Town of Brookhaven	Prescription Drug Co-pay only
Town of Clarkstown	Prescription Drug Co-pay only
Town of Huntington	Prescription Drug Co-pay only
Town of Smithtown	Prescription Drug Co-pay only
Town of Southold	Prescription Drug Co-pay only
Village of Lloyd Harbor	Prescription Drug Co-pay only
Village of Southampton	Prescription Drug Co-pay only
Yonkers School District	Prescription Drug Co-pay only

A Retired Employee of:	**Benefit:**
Town of Brookhaven Full Package	Prescription Drug Co-pay
Town of Southold	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***

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Physician Co-Pay & Prescription Drug Co-Pay

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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