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:               Benefit:
City of Long Beach                Prescription Drug Co-pay only
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 Ramapo                    Prescription Drug Co-pay and Physician Co-pay
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 Ramapo                    Prescription Drug Co-pay and Physician Co-pay
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.

• Effective January 1, 2013, an Explanation of Benefits (EOB) is required for all physician claims.

• Please do not use highlighter on print-outs.

CSEA Employee Benefit Fund 1-800-323-2732 www.cseaebf.com
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.

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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 ______________________

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Please allow up to 6 weeks for processing.

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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.

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MAIL COMPLETED FORM TO

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

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