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.
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.

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