WAPPINGERS CONGRESS OF TEACHERS WELFARE TRUST FUND

PRESCRIPTION CLAIM FORM

MAIL CLAIMS TO:
253 WEST 35TH STREET 12TH FLOOR NEW YORK, NEW YORK 10001

(914) 250-0700

MEMBER: FIRST	MIDDLE	LAST	Policyholder/Subscriber ID#
MEMBER: MAILING ADDRESS Number and Street		Apt	HOME PHONE ( )
			WORK PHONE: ( ) -
CITY	STATE	ZIP	Email Address:

	DATE PURCHASED	FIRST NAME PATIENT	RELATI-ONSHIP	PRESCRIPTION NO.	NAME OF PHARMACY	NAME OF DRUG	NAME OF DOCTOR	COST	CO-PAY AMOUNT
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
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16									
17									
18									
19									
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21									
22									
23									
24									
25									

TOTAL AMOUNT MUST BE ENTERED TO RECEIVE PAYMENT. $_____

PHARMACY DRUG PRINTOUTS MAY BE USED IN LIEU OF FILLING OUT INDIVIDUAL PRESCRIPTION LINES PROVIDING THAT THE PATIENT'S NAME, DATE OF PURCHASE, PRESCRIPTION NUMBER, NAME OF DRUG, PRESCRIBING DOCTOR'S NAME, DISPENSING PHARMACY AND THE COST OF THE PRESCRIPTION TO THE PATIENT IS ENTERED. MAXIMUM BENEFIT $200 PER CALENDAR YEAR PLUS $5 FOR EACH ADDITIONAL PRESCRIPTION.

IF MORE SPACE IS NEEDED, ATTACH AN ADDITIONAL CLAIM FORM.

I CERTIFY THAT THE ABOVE CHARGES WERE FOR THE BENEFIT OF MY ELIGIBLE FAMILY MEMBERS LISTED. I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING THESE PRESCRIPTIONS TO THE BENEFIT FUND OR THEIR REPRESENTATIVES FOR PURPOSE OF AUDIT OR VERIFICATION.

MEMBER SIGNATURE _____ DATE _____

PRESCRIPTION DRUG BENEFIT

WHO IS ELIGIBLE...

Member claiming for self and/or dependents

WHAT IS THE BENEFIT…

Once annually, up to a maximum of $200 plus $5 for each additional prescription, the Fund reimburses to a member the co-payment costs which have been paid within the calendar year for drugs prescribed by a medical doctor, osteopath or dentist. Prescription must be dispensed by a licensed pharmacist.

Prescription services which are covered included are those eligible under your primary prescription plan.

RESTRICTIONS...

Only one claim per year/per family is eligible.

Individual prescriptions not accompanied by a pharmacy printout or copy of receipt. Do not submit original receipts. (The Fund is not responsible for loss if originals are Submitted.)

The Fund prescription drug coverage is secondary to your primary prescription drug coverage.

CLAIMING...

Obtain a prescription drug claim form from the Fund office. The entire form must be completed in order to be eligible for payment. HOWEVER, PHARMACY DRUG PRINTOUTS MAY BE USED IN LIEU OF FILLING OUT INDIVIDUAL PRESCRIPTION LINES PROVIDING THAT THE PATIENT'S NAME, DATE OF PURCHASE, PRESCRIPTION NUMBER, NAME OF DRUG, PRESCRIBING DOCTOR'S NAME, DISPENSING PHARMACY AND THE COST OF THE PRESCRIPTION TO THE PATIENT IS ENTERED. THE CO-PAYMENT AMOUNT MUST BE INDICATED EITHER ON THE CLAIM FORM OR THE PHARMACY'S PRINT-OUT. All claim forms MUST contain a total dollar amount on the bottom of the claim or it will be returned to you without payment. All items listed will be subject to verification.

All claims must be received no later than 3/31 of the following year for reimbursement.

PRESCRIPTION DRUG CLAIM MAY ONLY BE SUBMITTED ONCE ANNUALLY

NOTE...

The same rules and regulations governing your primary prescription drug plan apply. The Fund does not cover prescription costs incurred by members beyond the amount payable by your primary prescription drug plan. If for some reason you had to pay full price for a prescription (perhaps your card was unavailable, or you were out-of- state), you MUST first submit the costs to your primary prescription plan prior to claiming. Do not submit your claim to the Fund unless all costs are backed by proof. Submissions at a later date will NOT be reconsidered for payment.

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD THE FUND OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACTUAL MATERIAL THERETO, COMMITS A FRAUD, WHICH IS A CRIME."
