UFCW LOCAL 1776 & PARTICIPATING EMPLOYERS HEALTH & WELFARE FUND

PRESCRIPTION INCENTIVE PROGRAM CLAIM FORM

To file correctly - before completing - please read instructions**

A. 1776 PARTICIPANT EMPLOYEE/RETIREE INFORMATION

1776 Participant's Name _____ Participant's SS# _____

Street Address _____ City _____ State _____ Zip Code _____

Employer (Company/Store) Name _____ Check One: Active _____ Retired _____

B. REQUEST FOR PRESCRIPTION COPAY/EARNED CREDIT REIMBURSEMENT

You must complete Section B before your claim can be considered

Name of other Prescription Plan Cardholder _____

Relationship of other Prescription Plan Cardholder to 1776 Participant _____

Name of Prescription Plan _____

Company/Employer Name - or - Name of the source supplying other Prescription Plan coverage

_____

Policy/ID Numbers of Other Prescription Plan _____

Non-Reimbursable Out-of-Pocket Costs being claimed _____

- Completion of Section C is optional –

C. SUMMARY OF EXPENSES FILED FOR EARNED CREDIT REIMBURSEMENT

Patient's Name & Birthdate	Type of Service Rendered	Service Date	Amount Charged

D. AUTHORIZATION & RELEASE OF INFORMATION

I hereby certify that the above expenses are not reimbursable to myself, my spouse or my dependents under any other form of insurance or Fund benefit or by any third party. I hereby authorize any pharmacy, physician, insurer or third party to release any information necessary to process this Prescription Incentive Program claim.

1776 Participant's Signature _____ Date _____

Revised 11/2007

*****see filing instructions on reverse side***

<<<<<INSTRUCTIONS FOR FILING A PRESCRIPTION INCENTIVE CLAIM>>>>>

IMPORTANT: WEB-SITE PRINT-OUTS ARE NOT ACCEPTABLE

SECTION A - List your own employee or retiree information as a 1776 Fund participant

SECTION B - List information for the other prescription card used in place of your 1776 drug card
- If possible - please attach a copy of the other prescription card used

ENCLOSE PHARMACY RECEIPTS & MATCHING CASH REGISTER RECEIPTS AS PROOF OF COPAY(S)

DO NOT STAPLE/TAPE/PASTE ANY ITEMS TO EACH OTHER - OR ANY OTHER SURFACE - DETACHMENT NECESSARY FOR PROCESSING OTHERWISE ITEMS MAY BE DAMAGED CAUSING A DELAY YOUR CLAIMS

PHARMACY RECEIPTS, PHARMACY GENERATED DRUG SUMMARIES[1] MUST INCLUDE:

- Pharmacy name & address
- Rx number
- Date prescription filled
- 11-digit National Drug Code (NOC # 00000-00-0000)[2]
- Medication name & dosage
- Quantity dispensed & days supply
- Name of other insurance/drug plan
- Amount (co-pay) paid by patient
- Prescribing physician's name

SECTION C - List non-reimbursable out-of-pocket expenses for you or your eligible dependents

ATTACH FULLY ITEMIZED BILLS FOR EXPENSES - BILLS MUST ALWAYS INCLUDE THE FOLLOWING:

Name & address (on official bill head) of the provider of service Patient's full name & date of birth

Description of each service or item supplied

Date & amount charged for each service or item supplied

We cannot accept balance due statements; unstamped credit card/cash receipts; cancelled checks or payment ledgers in place of itemized provider bills.

---------- If other insurance plans are responsible for bills submitted ----------

YOU MUST ENCLOSE EOBS

showing the other Plan's payment or denial of expenses claimed for reimbursement

EXAMPLE: Personal Choice; Aetna-US Healthcare; Medicare; NVA Vision; Delta Dental or other EOBs

MAIL COMPLETED CLAIM FORM & ENCLOSURES TO:
UFCW LOCAL 1776 & PARTICIPATING EMPLOYERS HEALTH & WELFARE FUND
3031 B WALTON ROAD
PLYMOUTH MEETING, PA 19462

IMPORTANT: Claim forms and earned credit documentation must be received in the Fund office *on or* ***before*** **June 30th of the calendar year following** the dates prescriptions are filled/medical expenses are incurred.

[1] DRUG SUMMARIES ARE INVALID UNLESS SIGNED & DATED BY THE DISPENSING PHARMACIST

[2] EARNED CREDIT CANNOT BE APPLIED FOR MEDICATION/DRUGS WITHOUT NOC NUMBERS

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