



**Central States Southeast and Southwest Areas
Health and Welfare Fund
Claims Processing – Prescription Drugs**

PO Box 5106
Des Plaines IL 60017-5106
1-800-323-5000

PRESCRIPTION DRUG CLAIM FORM

IMPORTANT INSTRUCTIONS
DO NOT SUBMIT THIS CLAIM UNTIL YOU HAVE \$75.00 IN PRESCRIPTION BILLS OR MORE THAN TEN (10) PRESCRIPTIONS.
SUBMIT ONLY ORIGINAL RECEIPTS (PHOTOCOPIES NOT ACCEPTABLE) WITH THIS FORM.
(SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS).
ADDITIONAL CLAIM FORMS MAY BE OBTAINED FROM YOUR LOCAL UNION.

PLACE "X" IN THE APPROPRIATE BOX:

ACTIVE PARTICIPANT RETIRED PARTICIPANT SPOUSE / FAMILY PROTECTION (PPO)

IF ADDRESS HAS CHANGED SINCE LAST CLAIM, PLACE 'X' IN THIS BOX <input type="checkbox"/>	MEMBER PLEASE PRINT ALL INFORMATION	MEMBER'S SOC. SECURITY NO.	MEMBER'S FIRST NAME	MIDDLE INITIAL	LAST NAME	MEMBER'S BIRTH DATE	MEMBER'S SEX	SPOUSE'S BIRTH DATE
						MO DAY YEAR	<input type="checkbox"/> M <input type="checkbox"/> F	MO DAY YEAR
MEMBER'S STREET ADDRESS		MEMBER'S CITY & STATE	ZIP CODE	LOCAL UNION	EMPLOYER NAME			

ARE YOU (MEMBER) COVERED BY ANOTHER GROUP BENEFIT PLAN? YES NO. HMO YES NO. MEDICARE YES NO IF YES, COMPLETE SECTION BELOW:

NAME OF OTHER COMPANY/ORGANIZATION PROVIDING BENEFITS: _____ ADDRESS OF OTHER ORGANIZATION PROVIDING BENEFITS (STREET, CITY, STATE, ZIP CODE): _____

IS YOUR SPOUSE EMPLOYED? YES NO IS SPOUSE COVERED BY ANY OTHER GROUP INSURANCE OR MEDICARE? YES NO

SPOUSE'S EMPLOYER: _____ ADDRESS OF SPOUSE'S EMPLOYER: _____

PATIENT INFORMATION	DISPENSING LIMITATIONS	MEMBER VERIFICATION
ENTER: Patient First Name Relationship To Member I – Individual Member H – Husband S – Son W – Wife D – Daughter	The amount of drug (including insulin) which may be dispensed per prescription or refill will be in quantities normally prescribed up to and including a thirty-four (34) day supply except for certain maintenance drugs which may be dispensed in quantities up to 100. Pharmacist: See Reverse Side	I hereby certify that these drugs and medicines were dispensed for and used solely by myself, my eligible spouse, or my other eligible dependents, by order of my physician or my eligible dependent's physician.
	MEMBER SIGNATURE _____	DATE _____

LINE	FIRST NAME	RELATIONSHIP TO MEMBER	NATIONAL		DRUG NAME	DAYS SUPPLY	AMOUNT	DATE OF PURCHASE	PRESCRIPTION NUMBER	PHARMACY LICENSE NUMBER	PHARMACIST SIGNATURE
			LABELER NO.	PRODUCT NO.							
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											

TOTAL BOX

IF RECEIPTS ARE NOT ATTACHED, PHARMACIST'S SIGNATURE MUST BE ON FORM BEFORE BENEFITS WILL BE PAID

FOR OFFICE USE ONLY – DO NOT WRITE ABOVE THIS LINE

USE THIS CLAIM FOR:

- Prescription Drug Claims Only

MEMBER INSTRUCTIONS

**TAKE THIS CLAIM FORM TO THE PHARMACY EACH TIME
PRESCRIPTION DRUGS ARE PURCHASED**

BE SURE: You have a receipt of each Prescription Drug
(Cash register receipts or photocopies are not acceptable)
The pharmacist signs for each Prescription Drug.

This is a family claim form. You may use one form for changes incurred by both you and your Covered Dependents. Submit this claim form when you have either \$75.00 in charges or a minimum of 10 prescriptions for you and your Covered Dependents.

1. Enter heading information, including the Social Security Number of our Participant/Retiree.
2. For each prescription, enter the following:
First name of the family member for whom the drug is prescribed and their relationship to you.
1= Individual Member **H** = Husband **W** = Wife **S** = Son **D** = Daughter
(Please note that dependent children are not covered by the Retiree Plan.)
3. Enclose original receipt (not cash register receipt) from the pharmacy substantiating all charges.
4. Sign the Claim Form.
5. Submit this claim form if:
10 or more prescriptions are entered
or
If you have \$75.00 or more in drug charges
or
6 months after your first prescription drug expense.
6. As necessary, obtain additional claim forms from your Local Union.

PHARMACIST INSTRUCTIONS

1. Enter each prescription separately.
2. Complete all items on each line.
3. Enter pharmacy License Number and sign each line item.
4. Do not include excluded drug benefits on this form.
5. Issue **GENERIC DRUGS** where possible.

ALL PAYMENTS WILL BE MADE DIRECTLY TO
THE INDIVIDUAL MEMBER.

BENEFITS MAY NOT BE ASSIGNED.

DISPENSING LIMITATIONS

The amount of drug (including insulin) which may be dispensed per prescription or refill will be in quantities normally prescribed up to and including a thirty-four (34) day supply except for certain maintenance drugs which may be dispensed in quantities up to 100.

SUMMARY OF DRUG BENEFITS COVERED

1. **Federal Legend Drugs:** Any medicinal substance which bears the legend: "Caution: Federal Law Prohibits dispensing without a prescription."
2. **State Restricted Drugs:** Any medicinal substance which may be dispensed by prescription only according to State Law.
3. **Compounded Medication:** Any medical substance which has at least one ingredient that is a Federal Legend or State Restricted Drug in a therapeutic amount.
4. **Insulin:** Available by prescription only. Includes insulin syringes.

SUMMARY OF EXCLUDED DRUG BENEFITS

1. Therapeutic devices or appliances (hypodermic needles, support garments, and other non-medicinal purposes)
2. All contraceptives including oral contraceptives and prophylactic devices even if prescribed for medicinal purposes.
3. Medications supplied to the Covered Individual in a Hospital or other treatment facility.
4. Drugs or medicines supplied to the Covered Individual by a physician or dentist.
5. Cosmetic, or beauty aids, dietary supplements and vitamins.
6. Immunizing agents, injectable, blood or blood plasma, or medication prescribed for parenteral administration, except insulin.
7. Medication for which the cost is recoverable under any Workmen's Compensation or Occupational Disease Law or any State or Federal Governmental agency. Any medication Furnished by any other Drug or Medical service for which no charge is made to the Covered Individual.
8. Any drugs labeled, "Caution - Limited by Federal Law to Investigational Use," or any experimental drug.