UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

Prescription Incentive Program
Claim Form

Before completing this form, please read the information on the reverse side.

A. GENERAL INFORMATION *(All participants must complete Part A)*

Participant's Name ____________________ S.S. No. ____________________

Street Address ____________ City ____________ State ____________ Zip ____________

Employer ____________ Store ____________ Date of Hire ____________

B. REQUEST FOR EARNED CREDITS AND REIMBURSEMENT OF OUT-OF-POCKET COSTS

(Participants who have used other prescription coverage must complete Part B to obtain reimbursement of their out-of-pocket costs and to have "earned credits" recorded to their "account" under the Program.)

Name of Policyholder ____________________

Address ____________________

Name of Carrier ____________________

Address ____________________

Policy Identification ____________________

Group ID Number ____________________

Out-of-Pocket Cost (i.e. co-pay, deductible) ____________________

C. SUMMARY OF MEDICAL EXPENSES INCURRED

(Participants who have incurred medical expenses and wish to be reimbursed from their "Earned Credits" must complete Part C)

Patient's Name	Patient's Date of Birth	Date of Service	Type of Service	Amount

I hereby certify that the above expenses have not been reimbursed to me or my spouse or dependents under any group health or other insurance plan of the Fund, or under any other insurance plan, program or arrangement that covers me or my spouse or my dependents, or by any other third party.

Participant's Signature ____________________ Date ____________

D. RELEASE OF INFORMATION *(All participants must complete Part D)*

I hereby authorize any pharmacy, physician or other insurance carrier to disclose/release any information necessary to process this Prescription Incentive Program Claim Form.

Participant's Signature ____________________ **Date** ____________

Phone number (include area code): Home (   ) ____________________

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INSTRUCTIONS FOR SUBMITTING A CLAIM FORM
UNDER THE
PRESCRIPTION INCENTIVE PROGRAM

This form was downloaded from www.benefitfunds.org

GENERAL INFORMATION

After you use other prescription coverage to obtain prescription drugs, you must submit the claim form and your itemized receipts to the Fund office. The Fund office will determine the "earned credits" to be recorded to your "account" under the Program. Your out-of-pocket costs (i.e., co-pays, deductibles) incurred by using the other prescription coverage will be reimbursed to you. After you incur medical expenses which cannot be reimbursed from any other source, you must submit another claim form and your itemized records (receipts, explanations of benefits, etc.) of these expenses to the Fund office. The Fund office will then determine the amount of any reimbursement to you from your "earned credits" under the Program. The "earned credits" recorded to your "account" under the Program for any calendar year can be used to reimburse you for medical expenses incurred by you and your family **only in that same calendar year**.

The deadline for submitting claim forms (and supporting documentation) for earned credits for using other prescription coverage and for medical expense reimbursements is June 30 of the calendar year following the year in which you use the other prescription coverage or incur the medical expense. For example, if you use other prescription coverage during the 1998 calendar year, you may submit a claim form to have "earned credits" recorded to your "account" under the Program and to be reimbursed for your out-of-pocket costs for using that other prescription coverage until June 30, 1999. Any unreimbursed medical expenses incurred by you and your family during the 1998 calendar year can also be submitted for reimbursement from your "earned credits" until June 30, 1999. All **unreimbursed** "earned credits" in your account for each year will be forfeited if you do not submit a claim form by this deadline. No balance of "earned credits" to your account for a calendar year will be carried forward to any later calendar year.

Please make copies of all bills and EOB's for your own records. Originals will not be returned to you. Mail completed claim form and attachments to:

UFCW Local 1776 and Participating Employers
Health and Welfare Fund
3031 B Walton Road
Plymouth Meeting, PA 19462
Attention: Prescription Incentive Program

EARNED CREDITS TO YOUR ACCOUNT AND REIMBURSEMENT OF OUT-OF-POCKET COSTS FOR USING OTHER PRESCRIPTION COVERAGE

After you use other prescription coverage, you should complete Parts A, B and D of the claim form and submit it with itemized bills which include the following information:

- Name and address of the Pharmacy
- Prescribing Physician
- Number days supply/dose
- NPC (National Product Code)
- Cost of medication
- Patient's full name
- Prescription name; Rx number
- Prescription strength
- Manufacturer
- Amount paid by participant

REIMBURSEMENT OF MEDICAL EXPENSES

After you incur medical expenses for you or your family, complete Parts A, C and D of the form and submit it with itemized bills which include the following information:

- Name and address of provider
- Type of service or supply
- Fee charged per service
- Patient's full name
- Month, day and year of service
- Payment made by the participant

IMPORTANT: Bills missing any of the above information will not be processed for earned credits or reimbursements. The Fund cannot accept cash register receipts, credit card receipts, cancelled checks, "balance due" statements or money order receipts in place of itemized bills. Please be sure all bills are legible.