

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 other 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 _____

C. SUMMARY OF EXPENSES FILED FOR EARNED CREDIT REIMBURSEMENT

Completing this section is optional

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

<<<<<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 PRESCRIPTION RECEIPTS & MATCHING CASH REGISTER RECEIPTS OR OTHER PROOF OF COPAY(S)

**DO NOT STAPLE/TAPE/PASTE ANY ITEMS TO EACH OTHER - OR ANY OTHER SURFACE -
DETACHMENT NECESSARY FOR PROCESSING MAY
DAMAGE ITEMS AND DELAY YOUR CLAIMS**

PRESCRIPTION RECEIPTS, PHARMACY/STORE GENERATED DRUG SUMMARIES MUST INCLUDE:

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

**EARNED CREDIT CANNOT BE APPLIED FOR MEDICATION/DRUGS WITHOUT NDC NUMBERS

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

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

Remember: 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 RD

PLYMOUTH MEETING, PA 19462

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

Revised 11/2007