PRESCRIPTION CLAIM FORM

MAIL CLAIMS TO:
Faculty Association Suffolk Community College
Benefit Fund
253 West 35th Street – 12tth Floor
New York, NY 10001-1907
(212) 505-5050

ADMINISTRATIVE USE ONLY
CLAIM #
RETURNED FOR:

MEMBER FIRST	MIDDLE	LAST	DATE EMPLOYED	BARGAINING UNIT
				☐ FA ☐ GUILD ☐ OTHER

MEMBER MAILING ADDRESS	**MEMBER'S ID NUMBER**
	_____
CITY, STATE, ZIP	☐ Active
	☐ Enhanced Plan Retiree
HOME PHONE ( ) WORK PHONE ( )	

. **TOTAL AMOUNT *MUST* BE ENTERED TO RECEIVE PAYMENT.**

TOTAL AMOUNT

(ATTACH PHARMACY PRINTOUT FOR EACH ELIGIBLE FAMILY MEMBER)

Prescription Drug Copayment Benefit

The Fund will reimburse the copayment incurred by the member and or his/her eligible dependent, up to $500.00 per calendar year plus an additional 1% (one percent) of all the copayment per eligible prescriptions submitted over $500.00. Prescriptions will be adjudicated in the order they are filled (chronologically). Eligible dependents are dependents who are deemed eligible for FA Benefits Fund Benefits. A dependent can be eligible for EMHP coverage, but not necessarily eligible for the Fund (e.g., the Fund does not cover adult children up to age 26)

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 eligible dependents

WHAT IS THE BENEFIT...
Once annually, 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. Prescriptions must be dispensed by a licensed pharmacist.

Prescription services which are covered include:
- Prescriptions which require compounding;
- Prescriptions for legend drugs (drugs which cannot be dispensed by a pharmacist without a prescription);
- Insulin on prescription;
- Allergenic solutions or extracts normally purchased at a pharmacy and authorized by a doctor;
- Prescribed vitamins;
- Prescribed birth control drugs.

DESCRIPTION OF BENEFIT...
Active member and retiree benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees.

RESTRICTIONS...
- Only one claim per family, per year 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. (Example: Employee Medical Plan of Suffolk County, HMO or spouse's coverage).
- No coverage is provided for over-the-counter drugs, vitamins, diet supplements, etc., which even though prescribed by a physician, can be legally purchased without a prescription.
- Allergy prescriptions unable to be filled at a licensed pharmacy.
- Drugs prescribed for cosmetic purposes.

CLAIMING...
Obtain a prescription drug claim form from your department's 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 line 26, or the claim will be returned to you without payment. All items listed will be subject to verification.

Submit your completed and signed form only after you have accumulated a *minimum annual* total of $500 for prescription drugs. If you do not meet the minimum prior to the end of the year, submit your claim for whatever the amount below that figure after the last day of that calendar year. In order to be eligible for coverage, your prescription drug claim MUST be submitted no later than April 30th of the year following the year charges were incurred. (Example: Covered expenses incurred from 1/1/2018 through 12/31/2018 must be claimed by 4/30/2019)

PRESCRIPTION DRUG CLAIM MAY ONLY BE SUBMITTED ONCE *ANNUALLY*

NOTE...
The same rules and regulations governing Suffolk County's 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."