

PRESCRIPTION DRUG CLAIM FORM

M A I L
Local No. 710
Health and Welfare Fund
Claims Processing - Prescription Drugs
 9000 W. 187th Street
 Mokena, IL 60448
 (773) 254-2500

IMPORTANT INSTRUCTIONS
 DO NOT SUBMIT THIS CLAIM UNTIL YOU HAVE \$50.00 IN PRESCRIPTION BILLS OR MORE THAN FIVE (5) PRESCRIPTIONS.
SUBMIT ONLY ORIGINAL ITEMIZED RECEIPTS WHICH LIST THE PRESCRIPTION DRUG NAME, PHARMACY NAME AND DOLLAR AMOUNT. (PHOTOCOPIES NOT ACCEPTABLE.)
 (SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS.)
 ADDITIONAL CLAIM FORMS MAY BE OBTAINED FROM LOCAL No. 710 HEALTH AND WELFARE FUND.

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

THESE QUESTIONS MUST BE ANSWERED

IS YOUR SPOUSE EMPLOYED YES NO

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

SPOUSES EMPLOYER

PATIENT INFORMATION

ENTER: Patient Name
 Relationship To Member
 I--Individual Member
 H--Husband
 W--Wife
 S--Son
 D--Daughter
 SS--Stepson
 SD--Stepdaughter

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.
 Pharmacist See Reverse Side

MEMBER VERIFICATION

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 dependents' physician.

MEMBER SIGNATURE _____ DATE _____ TEL. _____

LINE	FIRST NAME	RELATIONSHIP TO MEMBER	LAST NAME	DATE OF BIRTH	DRUG NAME	AMOUNT	DATE OF PURCHASE MONTH DAY YEAR	PRESCRIPTION NUMBER	PHARMACY LICENSE NUMBER	PHARMACIST SIGNATURE
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
TOTAL						BOX				

IF RECEIPTS ARE NOT ATTACHED, PHARMACISTS SIGNATURE MUST BE ON FORM BEFORE BENEFITS WILL BE PAID

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: Submit only original itemized receipts which list the prescription drug name, pharmacy name and dollar amount. (Photocopies Not Acceptable.)

This is a family claim form. You may use one form for charges incurred by both you and your Covered Dependents. Submit this claim form when you have either \$50.00 in charges or a minimum of 5 prescriptions for you and your Covered Dependents.

1. Enter heading information, including the Social Security Number of member.
2. For each prescription, enter the following:
First name of the family member for whom the drug is prescribed and their relationship to you.

I = Individual Member **H** = Husband **W** = Wife **S** = Son
D = Daughter **SS** = Stepson **SD** = Stepdaughter

3. Enclose original receipt (not cash register receipts) from the pharmacy substantiating all charges.

4. Sign the Claim Form.
5. Submit this claim form if:
5 or more prescriptions are entered
or
if you have \$50.00 or more in drug charges
or
6 months after your first prescription drug expense.
6. As necessary, obtain additional claim forms from your Local No. 710 Health and Welfare Fund.

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.
5. **Retin A:** Available by prescription only for members and eligible dependents who are under the age of twenty-three.
6. **Oral Contraceptives:** Available by prescription only.

SUMMARY OF EXCLUDED DRUG BENEFITS

1. Therapeutic devices or appliances (support garments and other non-medical substances).
2. Contraceptives and prophylactic devices even if prescribed for medicinal purposes except as noted above in the summary of drug benefits covered.
3. Medications supplied to the Covered Individual in a Hospital or other treatment facility.
4. Cosmetic or beauty aids, dietary supplements and vitamins (except prenatal vitamins).
5. Rogaine, Nicorette, and Norplant even if prescribed for medicinal purposes.
6. 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.
7. Any drug labeled, "Caution—Limited by Federal Law to Investigational Use," or any experimental drug.