FOR OFFICE USE ONLY – DO NOT WRITE ABOVE THIS LINE

CENTRAL STATES
SOUTHEAST AND
SOUTHWEST AREAS
HEALTH AND WELFARE FUND

MAIL TO

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

PO Box 5116
Des Plaines IL 60017-5116
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 ☐ MEMBER PLEASE PRINT ALL INFORMATION

MEMBER'S ID NUMBER	MEMBER'S FIRST NAME	MIDDLE INITIAL	LAST NAME	MEMBER'S BIRTH DATE MO	DAY	YEAR	MEMBER'S SEX ☐ M ☐ F	SPOUSE'S BIRTH DATE 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)*

THESE QUESTIONS MUST BE ANSWERED

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

ENTER: Patient First Name
Relationship To Member
I – Individual Member
H – Husband S – Son
W – Wife D – Daughter

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 dependent's physician.

MEMBER SIGNATURE DATE

LINE	FIRST NAME	RELATIONSHIP TO MEMBER	NATIONAL LABELER NO.	NATIONAL PRODUCT NO.	DRUG NAME	DAYS SUPPLY	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

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.