

Prescription Claim Form  
**Suffolk County Municipal Employees Benefit Fund**  
 30 Orville Drive, Suite D  
 Bohemia, New York 11716  
 (631) 319- 4099



ADMINISTRATIVE USE ONLY

CLAIM #
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Refer to Filing Instructions Before Completing  
 Please Contact the Fund for Maximum  
 Reimbursement Amounts  
 One Claim Per Family Per Year Accepted

EMPLOYEE: LAST	FIRST	EMPLOYEE SOCIAL SECURITY # OR PIN #
ADDRESS		DEPARTMENT
CITY	STATE	ZIP
HEALTH COVERAGE PLAN		OFFICE PHONE
		HOME PHONE

	PATIENT NAME	PHARMACY	\$ TOTAL PRINTOUTS FOR PATIENT
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

AMOUNT REIMBURSED BY ALTERNATE CO-PAYMENT INSURER  
 (Attach Statement From Other Insurer)

TOTAL

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**Co-payments Reimbursed By Any Other Insurer MUST Be Listed**

I certify that the above charges were for the benefit of my eligible family members and that I/we have not been reimbursed for these expenses from any other source. I authorize the release of any information concerning the prescriptions to the Benefit Fund or their representatives for the purpose of verification. I further certify that I have submitted **ALL EXPENSES** for reimbursement and waive right to any additional benefit for the year being filed.

EMPLOYEE SIGNATURE

DATE