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 #

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

EMPLOYEE: LAST	FIRST		BF #, PIN # or EMPLOYEE'S SOCIAL SECURITY # (Last 4 digits)
ADDRESS			DEPARTMENT
CITY	STATE	ZIP	OFFICE PHONE
HEALTH COVERAGE PLAN			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	

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