

# SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND

## Schedule A

### PRESCRIPTION CLAIM FORM

(This claim form is for **individual receipts** only and must be attached to **regular form**.)

*Individual receipts will not be accepted as proof of payment unless the pharmacy utilized cannot produce a printout.*

Employee \_\_\_\_\_ Social Security No. \_\_\_\_\_

### READ INSTRUCTIONS BEFORE COMPLETING AND SIGNING

PATIENT NAME	DATE OF PURCHASE	RELATIONSHIP	PRESCRIPTION NUMBER	PHARMACY NAME	NAME OF DRUG	CO-PAY AMOUNT
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
<b>TOTAL AMOUNT</b>						

MEMBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

1. Prescriptions must be listed in date order by patient.
2. Attached clear copies (do not send originals) of receipts must be clearly numbered with corresponding number on claim form.
3. Any receipts which have been altered must be signed by the pharmacist.
4. See primary claim form for filing instructions.