AFSCME CARE Plan

Return This form to:
OHIO AFSCME CARE PLAN
1603 East 27th Street
Cleveland, Ohio 44114
Phone: (216) 781-6420

STATEMENT OF CLAIM
PRESCRIPTION DRUG BENEFITS

☐ Check Box for Address Change

FOR ALL CLAIMS

NAME OF EMPLOYEE | MALE ☐ FEMALE ☐ | DATE OF BIRTH DAY MO. YEAR | EMPLOYED BY

EMPLOYEE'S HOME ADDRESS | CITY | STATE | ZIP | TELEPHONE

FOR DEPENDENT CLAIMS

NAME OF DEPENDENT | DEPENDENT SOC. SEC.# | MARRIED ☐ SINGLE ☐ | RELATIONSHIP TO EMPLOYEE | DATE OF BIRTH DAY MO. YEAR

IS DEPENDENT EMPLOYED? | NAME AND ADDRESS OF DEPENDENT EMPLOYER

FOR ALL CLAIMS

NATURE OF SICKNESS OR INJURY

IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?

ARE YOU OR YOUR DEPENDENT INSURED FOR PRESCRIPTION DRUG BENEFIT B OR DEVICES PROVIDED UNDER ANY OTHER EMPLOYER, UNION, ASSOCIATION, BLUE CROSS, BLUE SHIELD, OR OTHER INSURANCE PLAN? YES ☐ NO ☐

IF YES, INSERT POLICY NUMBER, NAME AND ADDRESS OF INSURANCE COMPANY OR ORGANIZATION PROVIDING SUCH BENEFITS FOR SERVICES.

Policy No. | Cert. No. | Name and Address

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT AND HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, EMPLOYER, UNION, INSURANCE COMPANY OR PRE-PAYMENT ORGANIZATION TO GIVE THE OHIO AFSCME CARE PLAN ANY ADDITIONAL INFORMATION REQUIRED IN CONNECTION WITH THIS CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

DATE | EMPLOYEE'S SIGNATURE | SOCIAL SECURITY NO.

ALL BENEFIT CLAIMS MUST BE SUBMITTED BY DECEMBER 31 AFTER THE END OF THE CALENDAR YEAR IN WHICH THE EXPENSE FOR THE PRESCRIPTION DRUG BENEFIT WAS PAID, FOR EXAMPLE, ALL BENEFIT CLAIMS FOR 2003 MUST BE SUBMITTED TO THE PROPER FUND OFFICE BY DECEMBER 31, 2004.

PHARMACIST'S STATEMENT

(FOLLOW INSTRUCTIONS BELOW)

PLEASE PRINT

PATIENT'S NAME _____ DATE _____

Name Of Drug	Date Filled	Quan.	# Days Supply	Rx Number	Rx New	Rx Refill	Legend By Law	Non Legend	Amount Charged

Is This Prescription For Obesity Yes ☐ No ☐ Birth Control Yes ☐ No ☐

NAME OF PHARMACY

ADDRESS OF PHARMACY | PHARMACIST'S SIGNATURE

TO EMPLOYEE:

1. **The "Employee's/Claimant's Statement" must be completed (All Questions Answered) and signed by you.**
2. **You will need a separate claim form for each covered member of your family for whom you are making a claim.**
3. **Ask your pharmacist to complete the "Pharmacist Statement" on the form. Be sure all questions are answered.**
4. **More than one (1) prescription drug may be indicated on each claim form provided the prescribed drugs are for the same person.**
5. **After your pharmacist has completed his section, please submit your claim form to the Plan Office.**
6. **You must sign the authorization for release of information above.**
7. **Please do not include purchases made in two (2) different calendar years on one (1) form.**

TO PHARMACIST:

1. **Please complete all questions in "Pharmacist's Statement".**
2. **More than one (1) prescription drug may be indicated on each claim form provided the prescribed drugs are for the same person.**
3. **If you have compounded the prescription, list the components in the "Name of Drug" column in the "Pharmacist's Statement" and circle only the legend drug(s).**