High-Cost Rx Program - Reimbursement Claim Form

PSC-CUNY Welfare Fund

Email this completed form to Jennifer Melfi, jmelfi@psccunywf.org

212-354-5230 ext. 1329

Pre-Requisite

I am covered by the PSC-CUNY Welfare Fund Catastrophe Major Medical Plan. ☐ Yes ☐ No

If Yes, Certificate # _____

I am covered by the NYSUT Catastrophe Major Medical Plan: ☐ Yes ☐ No

If Yes, Certificate # _____

IMPORTANT: If you answered YES and are covered by either of the plans above, an Explanation of Benefits (EOB) from the insurer MUST be included in your High-Cost Rx Plan reimbursement claim.

Member

Name (First, MI, Last) _____ Member SSN: _____

Date of Birth: _____ ☐ Active Employee ☐ Non-Medicare Retiree

Address: _____

City: _____ State: _____ Zipcode: _____

Preferred Email: _____ Preferred Telephone #: _____

If your current mailing address is different from the permanent address on file with the Welfare Fund, please inform us by emailing JMelfi@psccunywf.org.

Patient Information

Patient Name *(First, MI, Last)* _____ Relationship to Member: _____

Patient DOB: _____ Patient SSN: _____

Preferred Email: _____ Preferred Telephone #: _____

Other Insurance

Please indicate **other** health insurance available for this patient ONLY.

_____ _____ _____

Name of Employer | Insurance Carrier | Contract #

With this Application for Benefits under the PSC-CUNY Welfare Fund I hereby certify that I am eligible for Benefits and that all statements are true and accurate. I authorize the release of any necessary medical, employment or insurance information by service providers, insurers, employers, attorneys, or benefit administrators to PSC-CUNY Wellfare Fund for the purpose of evaluating and adjudicating this claim. I understand that I have a right to receive a copy of this authorization on request. I agree that a true image of this authorization is as valid as the original.

I have not applied for or received any other prescription drug reimbursement and/or copay assistance related to these claims from any other insurance plan.

_____ _____

Signature | Today's Date

Prescription Information

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
January thru March	*April thru June*	*July thru September*	*October thru December*
X			

Fill Date	Drug Name	Copay Amount
1/15/2019	ARNUITY ELPT INHALER	$124.26
2/23/2019	AZELASTINE SPRAY	$33.92
3/7/2019	BREO ELLIPTA INHALER	$356.28

***Please include prescription receipts for each prescription fill. Limit of one (1) submission per quarter. List each prescription fill separately.**

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
January thru March	*April thru June*	*July thru September*	*October thru December*
☐	☐	☐	☐

Fill Date	Drug Name	Copay Amount

Page Total =

Grand Total =