UCS $400 Combined Co-Pay Claim Form
Full Time Employee and Retirees

CSEA EMPLOYEE BENEFIT FUND

IMPORTANT - PLEASE READ THE FOLLOWING INFORMATION

This benefit includes a combined Prescription Drug Co-pay and Physician Co-pay Reimbursement.

This claim form should only be used if you are an eligible full time employee or an eligible retiree of the Unified Court System (UCS). Part time employees are not eligible for this benefit.

BENEFIT SUMMARY

The benefit maximum reimbursement per family is **$400 per calendar year.**

Complete this claim form and submit with your complete itemized pharmacy printout and/or Explanation Of Benefits (EOB) from your health insurance carrier in one combined claim, when you have reached the maximum benefit of $400 for the current calendar year (January 1st - December 31st). If you do not accumulate the maximum allowed, submit your claim after December 31 for what you did pay.

- **Deadline for claim submission is March 31 of the following year.**
- Pharmacy printout must indicate patient name, date of service, and name of prescription dispensed.
- Cash register receipts, original pharmacy/physicians receipts and cancelled checks are not acceptable.
- Please refer to the detailed instructions on the claim form for more information.
- An Explanation of Benefits (EOB) is required for all physician claims.
- Please do not use highlighter on print-outs.
- ***CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL***

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Full Time Employee and Retirees

CSEA EMPLOYEE BENEFIT FUND

Form must be completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached. Members are eligible for reimbursement once annually for physician office visit co-pays and prescription drug co-pays for themselves and their eligible dependents. **Deadline for claim submission is March 31 of the following year.**

Claim Year _____

Member's Name _____ EBF ID# _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

Daytime Phone # _____ Email _____

Member's Health Insurance Carrier(s) _____ Spouse's Health Insurance Carrier(s) _____

Member's Signature _____ Date _____

Please allow up to 6 weeks for processing.

IMPORTANT - PLEASE READ

Instructions: Complete this claim form and submit with your complete itemized pharmacy printout **and/or** Explanation Of Benefits (EOB) from your health insurance carrier in one combined claim, when you have reached the maximum benefit of $400 for the current calendar year (January 1st - December 31st). If you do not accumulate the maximum allowed, submit your claim after December 31 for what you did pay.

- ***Cash register receipts, original pharmacy/physician receipts and cancelled checks are not accepted for this benefit.***
- ***Please do not use highlighter on print outs***
- ***CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL***

MAIL COMPLETED FORM TO

CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12110-0516