RETURN TO:

SCCEA, Inc.
1300 Veterans Memorial Highway
Suite 130
Hauppauge, NY 11788
(1-631) 231-3983

SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION WELFARE FUND

PRESCRIPTION DRUG CLAIM FORM AND
HEALTH INSURANCE CO-PAYMENT REIMBURSEMENT CLAIM FORM

MEMBER INFORMATION

Member Name				Birth date	Social Security# LAST 4 DIGITS XXX-XX ☐☐☐☐
Street Address	City	State	Zip	Phone (Day Time)	Plan Status ☐ Single ☐ 2 Person ☐ Family

PRESCRIPTION DRUG REIMBURSEMENT - PLEASE ATTACH :

Pharmacy receipts or printouts with prescription information, charges and co-payment amounts, and or, Explanations of Benefits from all prescription coverage plans.

This benefit must be coordinated with any other plan under which a similar benefit is provided so that the total benefits available will not exceed 100% of the actual charges paid.

If a husband and wife are both full-time eligible employees and/or retirees, the Fund will pay a maximum of $300 per family in any calendar year; however, no more than $150 may be submitted for prescriptions for any one person.

CREDIT CARD RECEIPTS AND CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR PRESCRIPTION DRUG REIMBURSEMENT.

HEALTH INSURANCE CO-PAYMENT REIMBURSEMENT - PLEASE ATTACH :

The Explanation of Benefits from the Medical Plan showing all individual co-payments or Paid Receipts showing the co-payment.

The Fund will reimburse co-pay expenses for physician office visits and laboratory co-pay expenses to a maximum of $150 per family per year.
EXCLUSIONS AND LIMITATIONS

1) This benefit does not apply to costs covered by your regular health insurance plan except applicable co-payment expenses.
2) Non-physician providers, physical therapy, emergency room services, procedures performed at a hospital and dental co-payments are not eligible except mammogram co-payments not exceeding $25 qualify. Deductible and/or co-insurance payments are not eligible except for Medicare eligible retirees.

GENERAL INSTRUCTIONS

1) Claim forms should only be submitted once for each benefit, either when the $150 maximum has been met or, if less then $150, after January 1st following the year in which the expenses were incurred.

2) You may submit claims for both of the benefits indicated on this form.

3) ALL CLAIMS FOR MEDICAL CO-PAYMENT REIMBURSEMENT AND PRESCRIPTION DRUG REIMBURSEMENT MUST BE FILED BY March 31st of the following year.

AUTHORIZATION TO RELEASE INFORMATION: Authorization must be signed or payment will not be made.
I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Suffolk County Court Employees Association, Welfare Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

☐ **Prescription Drug Co-Pay Reimbursement Amount Expected $________**

☐ **Health Insurance Co-Pay Reimbursement Amount Expected $____________**

MEMBER'S SIGNATURE ______________________________ **DATE**__________________