New York City Electrical Division Health & Welfare Fund

P.O. Box 479 • Fresh Meadows, NY 11365-0479 • PHONE: (718) 820-1690 • FAX: (718) 820-1691

☐ ACTIVE
☐ RETIRED

PRESCRIPTION FORM

OFFICE USE ONLY

INSTRUCTIONS

Type or print ALL the information requested on this form and SIGN it below. Submit any ACTUAL bills or receipts for prescription purchases — MADE WITHIN THE PAST 120 DAYS ONLY — that are covered by this prescription plan. Use only ONE [1] form per patient.

CLAIMS SUBMITTED FOR PURCHASES MADE PRIOR TO 120 DAYS WILL NOT BE PAID!

PATIENT'S Last Name	First Name	Middle Initial	PATIENT'S Gender ☐ Male ☐ Female	PATIENT'S Date of Birth	Member's Local 3 Card #
Member's Last Name	First Name	Middle Initial	Prescription(s) for: (Use ONE [1] form per patient!) ☐ Member ☐ Spouse ☐ Covered Child		Member's Social Security #
Member's Home Address	Apartment #	City	State Zip Code	Member's Home Telephone Number ( )	

New York City Agency for Which Member Works or Worked	Member's Job Title	Member's Branch of Electrical Division:
Member's Work Location and Address	Member's Work Telephone Number ( )	☐ City Electricians ☐ Supervisor of Electricians ☐ Electrician's Helpers ☐ Communications Electricians - F.D.N.Y. ☐ Supervisor of Mechanics ☐ Electrical Inspectors ☐ Fire Inspectors - F.D.N.Y. ☐ O.T.B. Technicians ☐ Other: _____

Is PATIENT named above covered by any OTHER welfare fund OR group health insurance provider?
☐ Yes ☐ No If "Yes," supply the following information concerning the aforementioned plan(s):

Relationship of Patient to Member: _____ Plan Provider: _____

Plan Name: _____ Membership #: _____

Other Pertinent Information: _____

PRESCRIPTION INFORMATION

PURCHASE DATE	PRESCRIPTION #	NAME OF MEDICATION	CLASSIFICATION	QUANTITY	DOSES/DAY	PHARMACY NAME & LOCATION	PRICE
			☐ Name Brand ☐ Generic				
			☐ Name Brand ☐ Generic				
			☐ Name Brand ☐ Generic				
			☐ Name Brand ☐ Generic				
			☐ Name Brand ☐ Generic				
			☐ Name Brand ☐ Generic				
			☐ Name Brand ☐ Generic				
			☐ Name Brand ☐ Generic				
			☐ Name Brand ☐ Generic				

STATEMENTS OF CERTIFICATION & CONSENT

ANY PERSON WHO KNOWINGLY — AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY — FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A CRIME.

I hereby certify that the above drugs and medications were prescribed for treatment of the illness or injury of the eligible person listed as "Patient" above, and were purchased by me or any eligible dependent named above. I understand that copies of any bills, prescriptions and other data pertaining to the above items are to be retained by me for twelve [12] months from the date(s) of purchase and that the originals thereof are enclosed with this form.

SIGN HERE _____ Signature of Member _____ Date

TO ALL PHYSICIANS AND OTHER HEALTH PROFESSIONALS AND ALL HOSPITALS AND OTHER HEALTH CARE INSTITUTIONS:
You are authorized to provide the New York City Electrical Division Health & Welfare Fund and any independent claim administrators and consulting health professionals and utilization review organizations with whom the New York City Electrical Division Health & Welfare Fund has contracted information concerning health care, advice, treatment or supplies (including any related to mental illness) provided to the person named as "Patient" above. The information will be used for the purpose of evaluating and administering claims for benefits. The New York City Electrical Division Health & Welfare Fund may provide the employer named above with any benefits calculation used in payment of this claim for the purpose of reviewing the experience or operation of the policy or contract. This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a duplicate copy generated xerographically or electronically is as valid as the original.

SIGN HERE _____ Signature of Member _____ Date

RETURN COMPLETED FORM TO: *New York City Electrical Division Health & Welfare Fund P.O. Box 479 • Fresh Meadows, New York 11365-0479*