



*Important information about the Prescription Drug Co-pay
Reimbursement Plan:*

This claim form should only be used if you are an employee of New York State and employed in one of the following:

- ❖ Administrative Services Unit
- ❖ Institutional Services Unit
- ❖ Operational Services Unit
- ❖ Division of Military and Naval Affairs Unit
- ❖ Roswell Park Cancer Institute
- ❖ The New York State Liquidation Bureau

For the most efficient processing possible:

Submit your completed form along with an **itemized pharmacy printout** clearly indicating the co-pay amount. Cash register receipts, original pharmacy receipts and cancelled checks cannot be accepted. Please refer to the detailed instructions at the bottom of the claim form for more information.



Prescription Drug Co-Pay Reimbursement Claim Form

(STATE EMPLOYEES)

(800) 323-2732

Claim Form must be completed and signed by the CSEA Employee Benefit Fund Member. All required documentation must be attached. INCOMPLETE CLAIMS WILL BE RETURNED.

Mail completed claims to:
CSEA Employee Benefit Fund
P.O. Box 516
Latham, New York 12110-0516

Claim year you are submitting for: _____

Last First M.I. EBF ID #

Member's mailing address: Apt. #

Member's Home Address

City: State Zip Code

Member's Home Address

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Member's Daytime Phone No. Member's Employer Member's Signature

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

IMPORTANT - PLEASE READ

How to Claim this Benefit:

- Members who are enrolled in the New York State Health Insurance Program...
Only one claim per calendar year...
If you do not accumulate \$450 before the end of the year...
Submit your completed form along with an itemized PHARMACY PRINTOUT...