Prescription Drug Co-Pay Reimbursement Claim Form

Phone: 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

Last First Initial ___ ___ ___ - ___ ___ - ___ ___ ___
Member Name Social Security Number

Number & Street Apt. No
Member's Home Address

Village/Town/City State Zip Code
Member's Home Address

( ) ___ ___ ___ - ___ ___ ___ ___
Member's Daytime Phone No. Member's Employer Member's Signature

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

What Is This Benefit

- Members who are enrolled in the New York State Health Insurance Program (either the Empire Plan or Health Maintenance Organization) are entitled to reimbursement once annually for NYSHIP prescription drug co-pays only for themselves and their dependents.
- Only one claim per calendar year (January – December) is processed. Once your co-pays reach $300, the next $100 in prescription drug co-pays is reimbursable. To obtain the maximum benefit of $100, wait until your co-pay expenses reach $400 before filing your claim.
- If you do not accumulate $400 before the end of the year, submit your claim AFTER DECEMBER 31 for what you did pay over $300. The deadline for submission is March 31st of the following year for the co-pays accumulated during the previous Calendar Year.
- Submit your completed form with **ORIGINAL RECEIPTS** or an itemized **PHARMACY PRINTOUT** clearly indicating the co-pay amount, and a photocopy of your Empire Plan or HMO insurance card. *Cash register receipts, cancelled checks & credit card receipts are not acceptable.*