

**SHOPMEN'S LOCAL 527 BENEFIT FUND
2945 BANKSVILLE ROAD
PITTSBURGH, PA 15216
(412) 341-6183
Toll Free # 1 (800) 858-7870**

PRESCRIPTION DRUG CLAIM FORM

PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY

INSTRUCTIONS:

1. Please print and include all information requested. Forms not fully completed will be returned.
2. You must attach a receipt showing the amount paid for each prescription listed on the form. Your receipt must show: name of the pharmacy, patient's name, date of the purchase, prescription number, prescribing doctor, and charge for each prescription after all applicable discounts. RECEIPTS WILL NOT BE RETURNED.

Member's name _____ Social Security # _____

Employer _____

Address _____ Phone # _____

*** NEW MEMBERS / MEMBERS WITH COORDINATION OF BENEFITS USE THIS FORM. ALL OTHERS MUST USE PHARMACARE CARDS ***

Is this medication covered by any other group insurance plan: Yes () No ()

Name of Insurance Company _____

Address _____

Name of Policyholder _____ Group Number _____

Social Security Number _____ Deductible or Co-Payment _____

If for Dependant:

Name: _____ Relationship _____ Birthdate _____

NATURE OF ILLNESS OR INJURY (OFF JOB)	DATE OF PURCHASE	NAME OF MEDICATION	GENERIC Y / N	DAYS SUPPLY	QUANTITY	PRESCRIPTION NUMBER	PRESCRIBING PHYSICIAN	AMOUNT PAID

Drug Store Phone Number _____ Physician' Phone Number _____ TOTAL \$

I certify that the patient information entered above is correct, that the patient named is eligible for the benefits and that I have received the medication described. I also certify that the medication received is not for treatment of an on-the-job injury or covered by other insurance. I also authorize release of all information pertaining to this claim to the plan administrator or their representative.

Members Signature _____ Date _____

Date Paid: _____ Claim Number _____ Total Benefits Payable: \$ _____