OSSINING UNION FREE SCHOOL DISTRICT

Prescription Drug Claim for Reimbursement of Expenses in Excess of Out of Pocket Maximum

1. Employee's Name (Last Name) (First Name) (M.I.)

_____

Social Security No.: _____

Address: _____

Home Phone No.: Work Phone No.:

2. Ensure that the original receipts for each prescription *or* a pharmacy generated print out is attached and the Prescription Summary on the reverse side of this form is completed. If the original receipt is not available, a copy will be accepted if it is ac companied by another beneift plan's Explanation of Benefits (EOB). Receipts or print-outs must include:

   a. Name and address of Pharmacy
   b. Date prescription was filled
   c. Pharmacy prescription No.
   d. Name of drug/dose/quantity/ or 10 digit Nation Drug Product Code
   e. Amount of member's co-pay or expense

3. I hereby certify that the information contained on this form is correct and that I have not previously received reimbursement from any source fro the amount claimed on the reverse side of this form.

_____ _____

Member's Signature Date

4. Claims must be submitted to: Benefits Coordinator
   Ossining Union Free School District
   190 Croton Avenue
   Ossining, NY 10562

ENSURE THAT A COPY OF EACH RECEIPT IS ATTACHED OR THE PHARMACY PRINT-OUT TO THIS CLAIM PRESCRIPTION SUMMARY. (Attach additional sheets if necessary)

NAME OF PHARMACY	PRESCRIPTION NO.	DATE FILLED	AMOUNT BEING CLAIMED
TOTAL AMOUNT OF CLAIM FOR THIS PAGE.			