

**Subject:** Prescription Reimbursement Form

This form is intended to be used for reimbursement of prescription out-of-pocket expenses at the Fund's approved reimbursement rate and under approved coverage criteria in the following circumstances:

- Prescriptions that could not be purchased or on-line billed at a participating network pharmacy. (Example: Certain compound prescriptions would fall into this category)
- Unavailability of a network pharmacy
- Eligibility problems encountered at the pharmacy requiring an out-of-pocket payment
- For reimbursement of out-of-pocket co-payments when there is Coordination of Benefits (COB) with another insurance carrier

If you have any questions, please contact the Trust Fund Office at (323) 666-8910.



Ph: (323) 666-8910

# SOUTHERN CALIFORNIA DRUG BENEFIT FUND STATEMENT OF CLAIM FOR PRESCRIPTIONS

Return to:  
P.O. Box 27920  
Los Angeles CA 90027-0920

## PARTICIPANT INFORMATION

*(Please print and use one claim form for each patient. File within one year from date prescription is filled.)*

Is drug for treatment of occupational illness or injury?  Yes  No

Participant's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ or DF # \_\_\_\_\_

Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Employer \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Local \_\_\_\_\_ Is this claim a copayment from primary insurance?  Yes  No

Patient's Name \_\_\_\_\_ Relationship to Participant:  Self  Spouse  Child Patient's DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

*I hereby authorize any pharmacy or physician to disclose any records pertaining to medical history, treatment rendered and the drug and quantity of the prescription named hereon for the purpose of processing this claim.*

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

## PHARMACY COMPLETE -- Please print or paste labels. Use to submit one or more prescriptions for the patient listed above.

Name of Pharmacy \_\_\_\_\_ Pharmacy Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Name of Patient \_\_\_\_\_ Rx Compound?  Yes  No Did doctor indicate DNS Generic?  Yes  No

Prescription No. (one Rx only) \_\_\_\_\_ Date Filled \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Name of Prescribing Doctor \_\_\_\_\_

Prescribing Doctor's Phone No. (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Name of Drug \_\_\_\_\_ Strength \_\_\_\_ Manufacturer \_\_\_\_\_

Sig. \_\_\_\_\_ Quantity \_\_\_\_\_ No. of Days' Supply \_\_\_\_\_ Amt. \$ \_\_\_\_\_ NDC No. \_\_\_\_\_ Pkg. \_\_\_\_\_

Name of Pharmacy \_\_\_\_\_ Pharmacy Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Name of Patient \_\_\_\_\_ Rx Compound?  Yes  No Did doctor indicate DNS Generic?  Yes  No

Prescription No. (one Rx only) \_\_\_\_\_ Date Filled \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Name of Prescribing Doctor \_\_\_\_\_

Prescribing Doctor's Phone No. (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Name of Drug \_\_\_\_\_ Strength \_\_\_\_ Manufacturer \_\_\_\_\_

Sig. \_\_\_\_\_ Quantity \_\_\_\_\_ No. of Days' Supply \_\_\_\_\_ Amt. \$ \_\_\_\_\_ NDC No. \_\_\_\_\_ Pkg. \_\_\_\_\_

Name of Pharmacy \_\_\_\_\_ Pharmacy Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Name of Patient \_\_\_\_\_ Rx Compound?  Yes  No Did doctor indicate DNS Generic?  Yes  No

Prescription No. (one Rx only) \_\_\_\_\_ Date Filled \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Name of Prescribing Doctor \_\_\_\_\_

Prescribing Doctor's Phone No. (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Name of Drug \_\_\_\_\_ Strength \_\_\_\_ Manufacturer \_\_\_\_\_

Sig. \_\_\_\_\_ Quantity \_\_\_\_\_ No. of Days' Supply \_\_\_\_\_ Amt. \$ \_\_\_\_\_ NDC No. \_\_\_\_\_ Pkg. \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of Pharmacist \_\_\_\_\_ License No. \_\_\_\_\_ Date \_\_\_\_\_