# BTF

## BUFFALO CITY SCHOOL DISTRICT: PRESCRIPTION CO-PAY REIMBURSEMENT PLAN

***For prescription co-pays which exceed the contractual maximum or are different from IHA/Univera Formulary.***

☐ **Check here if you have a new address or this is your 1st claim submitted to Benefit Resource, Inc.**

| **PART 1** | **PART 2: Complete if this is your 1st claim or your address has changed** |
|---|---|
| **Employee Name:** | **Street or P.O. Box:** |
| **SSN:** | **City:** |
| **Employer:** **Buffalo CSD – BTF** | **State:** **Zip Code:** |

**PART 3: Employment Status**

Current employment status (check one): ☐ Active ☐ Retired on ____ / ____ /

**PART 4: Claim Period**

| RX expenses for the period (check one): | Claim received by BRI: | Claim processed by: |
|---|---|---|
| ☐ Jan 1 – Mar 31 | April 1 -30 | May 09 |
| ☐ Apr 1 – Jun 30 | July 1 - 31 | August 08 |
| ☐ Jul 1 – Sep 30 | October 1 - 31 | November 07 |
| ☐ Oct 1 – Dec 31 | January 1 - 31 | February 06 |

**PART 5: Insurance Coverage**

| BC/BS<br>Retirees prior to 11/1/93 | Plan B<br>(Formerly) Independent Health | Plan C<br>(Formerly) Univera | Plan D<br>Community Blue |
|---|---|---|---|
| ☐ Single<br>☐ Family | ☐ Single<br>☐ Family | ☐ Single<br>☐ Family | ☐ Single<br>☐ Family |

**PART 6: Employee Certification**

*1I request reimbursement for the attached prescription expenses. Each expense listed is for a prescription provided to me, my spouse or an eligible dependent for an immediate medical purpose and will not be reimbursed from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and that they cannot be claimed as credits or deductions on my personal income tax.*

*Signature:* _____ *Date:* _____

**INSTRUCTIONS FOR SUBMITTING YOUR CLAIM:**

1. Complete Part 1 of the claim form in full.
2. Complete Part 2 of the claim form if this is your 1st claim submitted to Benefit Resource, Inc. or your address has changed.
3. In Part 3, check your current employment status
4. In Part 4, check the claim period being submitted.
5. In Part 5, check the insurance in which you are enrolled.
6. In Part 6, sign and date the claim form after reading the Employee Certification.
7. **ATTACH A RECEIPT OR COMPUTERIZED PRINTOUT OF ALL PRESCRIPTION DRUG CO-PAYS PAID DURING THE TIME PERIOD INDICATED ABOVE.** This printout *must* include the following information:
   - The name of the provider
   - Your out-of-pocket cost for each prescription drug
   - The name of each prescription drug
   - The name of the person receiving the service
   - The date each prescription drug was purchased
8. Submit your completed claim form and related documentation to:

**ATTN: Claims Department**
**Benefit Resource, Inc.**
**245 Kenneth Drive**
**Rochester NY 14623-4277**

Benefit Resource, Inc.
Phone: (800) 473-9595, ext. 300
Website: www.BenefitResource.com

***Excel Entry***