Supplemental Benefit Fund

271 Porter Avenue, Buffalo, New York 14201, Phone: (716) 881-5462

PRESCRIPTION CO-PAY REIMBURSEMENT DEADLINE:

FRIDAY, MARCH 1, 2019 @ 5:00 P.M.

You must obtain a Computer Generated Roster from your Pharmacist
(ROSTERS FROM RITE-AID MUST BE the PATIENT HISTORY REPORT)

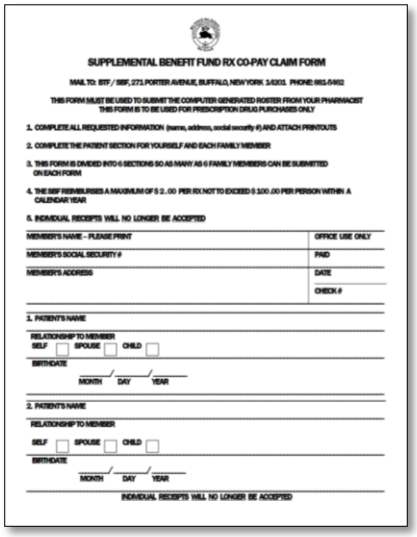
Pharmacy Roster For You & Each Eligible Family Member Must Include

1. Name of Provider
2. Rx Purchase Date
3. Name of Each Rx
4. Name of Patient
5. Cost You Paid

Obtain the Prescription Co-Pay claim form from your school, the SBF Office or download it from:

www.btfny.org

Click on BTF FORMS, Scroll to Supplemental Benefit Fund Forms, then to **Prescription Co-Pay forms – PRINT**



SUPPLEMENTAL BENEFIT FUND RX CO-PAY CLAIM FORM

MAIL TO: BTF / SBF, 271 PORTER AVENUE, BUFFALO, NEW YORK 14201 PHONE 881-5462

THIS FORM MUST BE USED TO SUBMIT THE COMPUTER GENERATED ROSTER FROM YOUR PHARMACIST
THIS FORM IS TO BE USED FOR PRESCRIPTION DRUG PURCHASES ONLY

1. COMPLETE ALL REQUESTED INFORMATION (name, address, social security #) AND ATTACH PRINTOUTS
2. COMPLETE THE PATIENT SECTION FOR YOURSELF AND EACH FAMILY MEMBER
3. THIS FORM IS DIVIDED INTO 6 SECTIONS SO AS MANY AS 6 FAMILY MEMBERS CAN BE SUBMITTED ON EACH FORM
4. THE SBF REIMBURSES A MAXIMUM OF $ 2..00 PER RX NOT TO EXCEED $ 100..00 PER PERSON WITHIN A CALENDAR YEAR
5. INDIVIDUAL RECEIPTS WILL NO LONGER BE ACCEPTED

MEMBER'S NAME - PLEASE PRINT	OFFICE USE ONLY
MEMBER'S SOCIAL SECURITY #	PAID
MEMBER'S ADDRESS	DATE
	CHECK #

1. PATIENT'S NAME
RELATIONSHIP TO MEMBER
SELF ☐ SPOUSE ☐ CHILD ☐
BIRTHDATE
MONTH DAY YEAR

2. PATIENT'S NAME
RELATIONSHIP TO MEMBER
SELF ☐ SPOUSE ☐ CHILD ☐
BIRTHDATE
MONTH DAY YEAR

INDIVIDUAL RECEIPTS WILL NO LONGER BE ACCEPTED

FOLLOW DIRECTIONS AT THE TOP OF
THIS FORM & FORWARD TO THE
BTF/SBF OFFICE
TO INSURE CONFIDENTIALITY
DO NOT FAX !!

Director: David Walker

Trustees: Phil Rumore - Joel Mercado
Sue Raichilson - Ruyvette Townsend
Maria Baker

(**December 2018**)