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

3. PATIENT'S NAME

RELATIONSHIP TO MEMBER
SELF ☐ SPOUSE ☐ CHILD ☐

BIRTHDATE
_____/_____/_____
MONTH DAY YEAR

4. PATIENT'S NAME

RELATIONSHIP TO MEMBER
SELF ☐ SPOUSE ☐ CHILD ☐

BIRTHDATE
_____/_____/_____
MONTH DAY YEAR

5. PATIENT'S NAME

RELATIONSHIP TO MEMBER
SELF ☐ SPOUSE ☐ CHILD ☐

BIRTHDATE
_____/_____/_____
MONTH DAY YEAR

6. PATIENT'S NAME

RELATIONSHIP TO MEMBER
SELF ☐ SPOUSE ☐ CHILD ☐

BIRTHDATE
_____/_____/_____
MONTH DAY YEAR