IRONWORKERS LOCAL 11 WELFARE FUND

12 Edison Place
Springfield, NJ 07081
973-376-7230
www.ironnj.com

Prescription Reimbursement Form

General Instructions:

- This form is to be used for claiming prescription drug benefits provided to eligible Ironworkers and their dependents.
- All information and signatures requested must be filled in completely. If you need additional space, attach a second form.
- All items listed will be subject to verification with pharmacists and doctors by the Fund Office or their representatives.
- Approved prescription reimbursement forms will be paid directly to the ironworker only.

Copayments for prescriptions obtained under this Plan are not reimburseable and are the patient's responsibility.

Items Covered by the Prescription Plan:

- Prescriptions which require compounding. Itemize ingredients.
- Prescriptions for legend drugs (drugs which cannot be dispensed without a prescription).
- Drugs covered by this plan must be prescribed by a licensed medical doctor or osteopathic physician.
- All prescriptions must be dispensed by licensed pharmacies.

Items Not Covered by the Presciption Plan (Eligible Purchases):

- No coverage is provided for over the counter drugs (OTC), vitamins, diet supplements, etc, which even though prescribed by a physician can be legally purchased without a prescription.
- Coverage does not include drugs administered to inpatients of any hospital.
- Coverage does not include drugs administered in connection with a Workmen's Compensation Claim.
- No allowances for purchases made more than one (1) year prior to the date the claim is received at Fund Office.

Maintenance or Long Term Prescriptions must be obtained through the Mail Order Program.

Prescriptions obtained without using your Prescription Plan ID card are not reimburseable by the Fund.

For additional information on Prescription Benefits, coverages and exclusions, please see your Summary Plan Description (SPD).

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Ironworker Name **Street Address** **City, State and Zip Code**

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Social Security # **Telephone #**

Please attach a pharmacy receipt for each prescription listed below:

Patient Name	Fill Date	Prescribing Doctor	Prescription (Rx) #	Name of Medication	Price for Each Item
				Total Amount of Claim	$

I certify that all information furnished above is true, complete and correct. I understand that the Trustees of this Fund resrve the right at all times to verify each item on this claim, including the original prescription.

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Member Signature **Date**