MOUNT VERNON FEDERATION OF TEACHERS WELFARE FUND

MEDICAL AND/OR PRESCRIPTION CO-PAYMENT REIMBURSEMENT CLAIM FORM (FOR MEMBERS WITH SWSCHP COVERAGE)

RETURN TO:

Administrative Services Only, Inc.
Department 06-PDP/Copay
PO Box 9005
Lynbrook, NY 11563-9005
(516) 396-5500
(877) 390-5845
WWW.ASONET.COM

Effective July 1, 2011: Member, spouse and eligible dependent children are entitled to medical and/or prescription co-payment reimbursement every plan year (July 1-June 30). $200 per covered individual. $400 family maximum.

Co-payment reimbursement may include any combination of the following: $10.00 per office visit, $25.00 Hospital Out-Patient Services, $100 Hospital Patient Admission, $25.00 Mammography, $50.00 Ambulance, or any Prescription Co-Payment up to the maximum allowed.

MEMBER INFORMATION

Member Name	Birth date	Social Security#
		XXX- XX- ☐☐☐☐

Street Address	City	State	Zip	Plan Status
				☐ Single ☐ 2 Person ☐ Family

CLAIMANT INFORMATION

Claimant Name	Birthdate	Relationship to Member

PHARMACY/PROVIDER INFORMATION

Name of Pharmacy or Provider	Telephone#	PHARMACY NABP # or PROVIDER TAX ID NUMBER	
Street Address	City	State	Zip Code

FOR PRESCRIPTION CO-PAYMENT REIMBURSEMENT PLEASE ATTACH EITHER:

(A) CVS Caremark printout with your expenditures and co-payments indicated. This can be obtained from the CVS Caremark website, www.caremark.com; or by mail by calling CVS Caremark customer service at (844) 260-5889. You will need your I.D. number and be able to answer appropriate questions for verification purposes.

(B) Pharmacy receipts or printouts with prescription information, charges and co-payment amounts.

FOR MEDCIAL CO-PAYMENT REIMBURSEMENT ATTACH:

(A) The Explanation of Benefits from the Medical Plan

CREDIT CARD RECEIPTS AND CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR PRESCRIPTION CO-PAYMENT REIMBURSEMENT.

ALL CLAIMS FOR REIMBURSEMENT MUST BE RECEIVED BY JUNE 30TH OF THE FOLLOWING PLAN YEAR

AUTHORIZATION TO RELEASE INFORMATION: Authorization must be signed or payment will not be made.

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Mount Vernon Federation of Teachers Welfare Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct. **Authorization must be signed or payment will not be made.**

MEMBER'S SIGNATURE _____ **DATE**_____