



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 \$ 3.00 PER RX NOT TO EXCEED \$ 150.00 PER PERSON WITHIN A CALENDAR YEAR**
- 5. INDIVIDUAL RECEIPTS WILL NOT 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

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