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 WITH 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, Birth Dates, Social Security #*) FOR YOURSELF AND EACH COVERED FAMILY MEMBER AND ATTACH COMPUTER ROSTERS (*Dependents Are Covered Until Their 23rd Birthday*).**

2. **THE SBF REIMBURSES A MAXIMUM OF $ 2 PER RX (*For Each 30 Day Supply*) NOT TO EXCEED $ 100 PER PERSON WITHIN A CALENDAR YEAR.**

3. **THIS FORM IS DIVIDED INTO 7 SECTIONS SO AS MANY AS 7 FAMILY MEMBERS CAN BE SUBMITTED ON EACH FORM**

4. **COMPUTER PRINTOUTS MUST INCLUDE: *Name of Patient, Purchase Date, Name of Each RX, Name of Provider, Cost You Paid, and the Number of Days Supplied. You Might Be Eligible for More Than $2 per RX if 60 or 90 Day Supply is Listed on the Pharmacy Printout. Individual Receipts Will Not Be Accepted.***

Member's Name – Please Print

_____

Member's Social Security #

_____

Member's Address

_____

_____

1. Patient's Name:

_____

Relationship To Member:

Self ☐ **Spouse** ☐ **Child** ☐

_____

Birthdate:

_____ /_____ /_____
Month Day Year

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2. Patient's Name:

_____

Relationship To Member:

Self ☐ **Spouse** ☐ **Child** ☐

_____

Birthdate:

_____ /_____ /_____
Month Day Year

(OVER)

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

7. Patient's Name:

Relationship To Member:

Self ☐ Spouse ☐ Child ☐

Birthdate:

_____ /_____ /_____
Month Day Year