SOUTHERN CALIFORNIA PIPE TRADES HEALTH AND WELFARE FUND
501 Shatto Place 5th Floor, Los Angeles, CA 90020
(213) 385 6161 or California only (800) 595 7473

PRESCRIPTION DRUG CLAIM FORM - PENSIONER PLAN

Member's Name _____ Member's S.S. No. _____

Member's Address _____

Patient's Name _____ Patient's S.S. No. _____

Patient's Address _____

If you or your eligible dependent incurs expense for drugs or medicines lawfully obtainable only upon prescription of a Physician, Podiatrist or Dentist **when related to a diagnosis**, and dispensed by a licensed pharmacy, you will be reimbursed the amount of the charges incurred up to $600 per calendar year after applying a separate $50 deductible.

A claim for reimbursement may be submitted each time within a Calendar Year the Allowable Charge drugs or medications per individual total $200 or more. If the charges do not exceed $200 per individual, the claim for reimbursement should be made in the month of January following the Calendar Year in which the charges were incurred.

Date of Purchase	Name of Medication	RX Number	$ Amount

Attach itemized prescription receipts or Computer Printouts to this form and forward to the Fund Office. Receipts and Printouts must include the patient's name, the date prescription filled, the name of the medication, the prescription number , the cost of the prescription and the name of the prescribing physician.

COMPUTER PRINTOUTS OF PRESCRIPTIONS MUST BE SIGNED AND DATED BY THE PHARMACIST.

REVISED JUNE 2001