UFCW – EMPLOYERS BENEFIT PLANS OF NORTHERN CALIFORNIA

PRESCRIPTION DRUG PROGRAM

DIRECT REIMBURSEMENT CLAIM FORM

Pharmacist must complete all items

PLEASE PRINT

PARTICIPANT'S SOCIAL SECURITY NUMBER

☐☐☐ – ☐☐ – ☐☐☐☐

PARTICIPANT'S NAME

ADDRESS

CITY ST ZIP

IS PRESCRIPTION FOR TREATMENT OF OCCUPATIONAL ACCIDENT? ☐ YES ☐ NO

CLAIMS MUST BE FILED WITHIN 90 DAYS OF DATE DISPENSED

☐ PARTICIPANT

☐ SPOUSE

☐ DEPENDENT CHILD — BIRTHDATE: MO. YEAR

I Certify that the drugs received pursuant to this claim were prescribed for the named patient who is eligible according to the rules of the Plan and authorize the release of all information concerning this claim to:
UFCW– EMPLOYERS BENEFIT PLANS OF NORTHERN CALIFORNIA

SIGNATURE OF PARTICIPANT X ______________________________

NC-16

PHARMACY NAME

ADDRESS

CITY ST ZIP

DATE FILLED	NEW	REFILL	RX NUMBER

Days Supply	QUANTITY	☐ EACH ☐ CC ☐ GRAM	PRESCRIBING DOCTOR ☐ MD ☐ DO ☐ DDS ☐ POD

PLEASE PRINT

NATIONAL DRUG CODE

MANUFACTURER

PRODUCT

PKG.

Important Print Numbers In Right Most Blocks

MEDICATION NAME – FORM, STRENGTH, MANUFACTURER

PATIENT'S NAME

PHARMACIST'S SIGNATURE X ______________________________

TOTAL RX CHARGE