

**UFCW – EMPLOYERS BENEFIT PLANS OF NORTHERN CALIFORNIA
REQUEST FOR REIMBURSEMENT OF PRESCRIPTION DRUG CO-PAYMENTS**



**PRESCRIPTION
DRUG PROGRAM**

Pharmacist must complete all items

PLEASE PRINT

PARTICIPANT'S SOCIAL SECURITY NUMBER			
□ □ □ - □ □ - □ □ □ □			
PARTICIPANT'S NAME			
ADDRESS			
CITY	ST	ZIP	

PHARMACY NAME		
ADDRESS		
CITY	ST	ZIP

NAME OF THE GROUP PROVIDING THE PRESCRIPTION DRUG BENEFIT
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PLEASE PRINT

If your prescription drugs were provided by a *Prescription Plan* (other than Retail Clerks) you may be eligible for reimbursement of the co-payment made for these prescriptions.

This is a claim for reimbursement of these co-payments.
Claims must be filed within 90 days of date paid.

Complete a separate card for each person. This claim is filed for:

PARTICIPANT SPOUSE DEPENDENT CHILD

PLEASE NOTE: Only **one** card needs to be completed if more than one prescription for the **same person** is filled on the **same day**.

DATE FILLED	NUMBER OF PRESCRIPTIONS	TOTAL AMOUNT PAID BY INSURANCE	TOTAL AMOUNT OF CO-PAYMENT

PATIENT'S NAME

PHARMACIST'S SIGNATURE X _____

NC-25 6/98

SIGNATURE OF PARTICIPANT X _____
