Subject: Prescription Reimbursement Form

This form is intended to be used for reimbursement of prescription out-of-pocket expenses at the Fund's approved reimbursement rate and under approved coverage criteria in the following circumstances:

- Prescriptions that could not be purchased or on-line billed at a participating network pharmacy. (Example: Certain compound prescriptions would fall into this category)
- Unavailability of a network pharmacy
- Eligibility problems encountered at the pharmacy requiring an out-of-pocket payment
- For reimbursement of out-of-pocket co-payments when there is Coordination of Benefits (COB) with another insurance carrier

If you have any questions, please contact the Trust Fund Office at (323) 666-8910.

The Southern California Drug Benefit Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-323-666-8910.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-323-666-8910。

Ph: (323) 666-8910

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

STATEMENT OF CLAIM FOR PRESCRIPTIONS

Return to:
P.O. Box 27920
Los Angeles CA 90027-0920

PARTICIPANT INFORMATION

(Please print and use one claim form for each patient. File within one year from date prescription is filled.)

Is drug for treatment of occupational illness or injury? ☐ Yes ☐ No

Participant's Last Name ______ First Name ______ SSN _ _ _ - _ _ - _ _ _ _ or DF # _ _ _ _ _ _ _

Street Address ______ City/State/Zip ______ Employer ______

Phone (_ _ _) _ _ _ -- _ _ _ _ Local _ _ _ _ Is this claim a copayment from primary insurance? ☐ Yes ☐ No

Patient's Name ______ Relationship to Participant: ☐ Self ☐ Spouse ☐ Child Patient's DOB _ _ / _ _ / _ _ _ _

I hereby authorize any pharmacy or physician to disclose any records pertaining to medical history, treatment rendered and the drug and quantity of the prescription named hereon for the purpose of processing this claim.

☒ ______ _ _ / _ _ / _ _ _ _

Signature of Participant Date

PHARMACY COMPLETE -- *Please print or paste labels. Use to submit one or more prescriptions for the patient listed above.*

Name of Pharmacy ______ Pharmacy Address ______ City/State/Zip ______

Name of Patient ______ Rx Compound? ☐ Yes ☐ No Did doctor indicate DNS Generic? ☐ Yes ☐ No

Prescription No. (one Rx only) _ _ _ _ _ _ _ _ _ _ Date Filled _ _ / _ _ / _ _ Name of Prescribing Doctor ______

Prescribing Doctor's Phone No. (_ _ _) _ _ _ -- _ _ _ _ Name of Drug ______ Strength ____ Manufacturer ______

Sig. _____ Quantity _ _ _ _ No. of Days' Supply _ _ _ Amt. $ _ _ _ _ . _ _ NDC No. _ _ _ _ _ _ _ _ _ _ _ Pkg. _ _

Name of Pharmacy ______ Pharmacy Address ______ City/State/Zip ______

Name of Patient ______ Rx Compound? ☐ Yes ☐ No Did doctor indicate DNS Generic? ☐ Yes ☐ No

Prescription No. (one Rx only) _ _ _ _ _ _ _ _ _ _ Date Filled _ _ / _ _ / _ _ Name of Prescribing Doctor ______

Prescribing Doctor's Phone No. (_ _ _) _ _ _ -- _ _ _ _ Name of Drug ______ Strength ____ Manufacturer ______

Sig. _____ Quantity _ _ _ _ No. of Days' Supply _ _ _ Amt. $ _ _ _ _ . _ _ NDC No. _ _ _ _ _ _ _ _ _ _ _ Pkg. _ _

Name of Pharmacy ______ Pharmacy Address ______ City/State/Zip ______

Name of Patient ______ Rx Compound? ☐ Yes ☐ No Did doctor indicate DNS Generic? ☐ Yes ☐ No

Prescription No. (one Rx only) _ _ _ _ _ _ _ _ _ _ Date Filled _ _ / _ _ / _ _ Name of Prescribing Doctor ______

Prescribing Doctor's Phone No. (_ _ _) _ _ _ -- _ _ _ _ Name of Drug ______ Strength ____ Manufacturer ______

Sig. _____ Quantity _ _ _ _ No. of Days' Supply _ _ _ Amt. $ _ _ _ _ . _ _ NDC No. _ _ _ _ _ _ _ _ _ _ _ Pkg. _ _

☒ ______ ______ _ _ / _ _ / _ _ _ _

Signature of Pharmacist License No. Date

Rev. 04252008