# HASTINGS TEACHERS' ASSOCIATION BENEFIT FUND

Statement of Claim for: Out of Pocket Prescription Costs
Claim Year: September 1 to August 31

**MAIL TO:**
**Administrative Services Only, Inc.**
PO Box 9005, Dept. 29-M
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238
**Or**
**UPLOAD *ALL* paperwork to ASONET.com**

**PLEASE SEE INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM ON HOW TO FILE A CLAIM.**

**CLAIM YEAR:** SEPTEMBER 1 TO AUGUST 31

**CLAIM YEAR BENEFIT:** YOU WILL BE REIMBURSED 50% OF THE FIRST $600 OF YOUR OUT-OF-POCKET PRESCRIPTION COSTS. THE MAXIMUM PLAN PAYMENT WILL BE $300.

**FILING DEADLINE:** ALL CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF CLAIM YEAR END.

## MEMBER INFORMATION

| MEMBER NAME | BIRTH DATE | MALE ☐ FEMALE ☐ | | |
|---|---|---|---|---|
| ADDRESS | APT. NO. | CITY | STATE | ZIP CODE |
| SOCIAL SECURITY NO. ☐☐☐-☐☐-☐☐☐☐ | | DAYTIME TELEPHONE NUMBER:<br>EVENING TELEPHONE NUMBER: | | |

**LIST THE INDIVIDUAL PRESCRIPTION AND ATTACH MATCHING PHARMACY BILLS**

| | RX NUMBER | DATE | COST OF RX | | RX NUMBER | DATE | COST OF RX |
|---|---|---|---|---|---|---|---|
| 1 | | | | 11 | | | |
| 2 | | | | 12 | | | |
| 3 | | | | 13 | | | |
| 4 | | | | 14 | | | |
| 5 | | | | 15 | | | |
| 6 | | | | 16 | | | |
| 7 | | | | 17 | | | |
| 8 | | | | 18 | | | |
| 9 | | | | 19 | | | |
| 10 | | | | 20 | | | |

**TOTAL AMOUNT CLAIMED: $_____**

## MEMBER SIGNATURE-REIMBURSEMENTS ARE PAYABLE TO THE MEMBER ONLY.

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WERE THE AMOUNT BILLED.

_____ _____
**SIGNATURE OF MEMBER** **DATE**

# HASTINGS TEACHERS' ASSOCIATION BENEFIT FUND

**Statement of Claim for**: Out of Pocket Prescription Costs
**Claim Year:** September 1 to August 31

**CLAIM YEAR:** SEPTEMBER 1 TO AUGUST 31

**CLAIM YEAR BENEFIT:** YOU WILL BE REIMBURSED 50% OF THE FIRST $600 OF YOUR OUT-OF-POCKET PRESCRIPTION COSTS. THE MAXIMUM PLAN PAYMENT WILL BE $300.

**FILING DEADLINE:** ALL CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF CLAIM YEAR END.

**QUALIFIED EXPENSES:** INCLUDE ANY OUT OF POCKET EXPENSES INCURRED FOR PRESCRIPTIONS PRESCRIBED BY A PROVIDER, WHETHER THAT PRESCRIPTION IS COVERED BY YOUR DRUG PROGRAM OR NOT.

**HOW TO FILE A CLAIM:**

- LIST THE INDIVIDUAL PRESCRIPTIONS ON THE FRONT OF THE FORM AND ATTACH MATCHING PHARMACY BILLS. YOU CAN OBTAIN A SUMMARY OF PRESCRIPTION COSTS FROM YOUR PHARMACIST OR DIRECTLY FROM THE MEDCO WEBSITE FROM THE CLAIMS AND BALANCES LINK.

- BEGINNING SEPT 1, 2010 SUBMIT YOUR CLAIM AFTER YOU HAVE ACCUMULATED $600 IN OUT OF POCKET PRESCRIPTION COSTS OR AT THE END OF THE CLAIM YEAR TO ENSURE YOU GET THE FULL BENEFIT. DO NOT SUBMIT YOUR CLAIM UNTIL THE END OF THE PLAN YEAR UNLESS YOU HAVE ALREADY MET THE FULL AMOUNT OF THE BENEFIT.

- FAILURE TO FILE REQUIRED DOCUMENTATION AND/OR SIGN EACH CLAIM FORM WILL CAUSE DELAY IN THE PROCESSING OF YOUR CLAIM AND MAY CAUSE A DENIAL OF YOUR CLAIM.