

# New York State Employees Prescription Drug Co-Pay Reimbursement Claim Form



Form must be completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached.  
**Incomplete forms will be returned.**

## MAIL COMPLETED CLAIMS TO

CSEA Employee Benefit Fund  
PO Box 516  
Latham, NY 12110-0516

Claim Year \_\_\_\_\_

Member's Name \_\_\_\_\_ EBF ID# \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Daytime Phone # \_\_\_\_\_ Email \_\_\_\_\_

Member's Health Insurance Carrier(s) \_\_\_\_\_ Spouse's Health Insurance Carrier(s) \_\_\_\_\_

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

***Please allow up to 6 weeks for processing.***

## IMPORTANT — PLEASE READ

- Members who are enrolled in the New York State Health Insurance Program (either the Empire Plan or Health Maintenance Organization) are entitled to reimbursement once annually for NYSHIP prescription drug co-pays and covered prescriptions less than the co-pay for themselves and their eligible dependents.
- Only one claim per calendar year (January-December) is processed. Once your co-pays reach \$300, the next \$150 in prescription drug co-pays is reimbursable. To obtain the maximum benefit of \$150, wait until your co-pay expenses reach \$450 before filing your claim.
- If you do not accumulate \$450 before the end of the year, submit your claim **after December 31** for what you did pay over \$300. **The deadline for submission is March 31 of the following year** for the co-pays accumulated during the previous calendar year.
- Submit your completed form along with an **itemized pharmacy printout** clearly indicating the co-pay amount.
- Cash register receipts, original pharmacy receipts, and cancelled checks are not acceptable. Charges for "over the counter" drugs, prescriptions not covered by your prescription plan and brand/generic differentials are not reimbursed.