OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUNDS

P O BOX 7067, PASADENA, CA 91109

FEE-FOR-SERVICE

PRESCRIPTION DRUG CLAIM FORM

ENGINEER'S SOC. SEC. NO.: _____-_____-_____ ENGINEER'S NAME: _____

PATIENT NAME: _____ PATIENT DATE OF BIRTH: ____/____/____ RELATIONSHIP TO ENGINEER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

MEMBER'S HOME PHONE NO.: (_____) _____-_____ IS CLAIM/RX WORK RELATED? YES ___ NO ___

** COMPLETION OF THIS ENTIRE FORM (BY A LICENSED PHARMACIST) IS REQUIRED FOR REIMBURSMENT **

RX #	NAME & STRENGTH OF MEDICATION	NEW RX	RE-FILL	METRIC QUANTITY	DAYS SUPPLY	NDC # OF MEDICATION	RX PRICE	DATE WRITTEN	DATE FILLED	PRESCRIBER DEA #

PHARMACY NAME: _____ NABP NUMBER: _____

PHARMACY PHONE #: (_____) _____-_____ PHARMACIST'S SIGNATURE: _____

REIMBURSMENT FOR ALL PRESCRIPTIONS PURCHASED AT NON-CONTRACT PHARMACIES ARE LIMITED TO A SIXTY (60) DAY SUPPLY (ON EACH INDIVIDUAL MEDICATION) LIFETIME, WITH NO EXCEPTIONS. FURTHER MEDICATION SUPPLY MUST BE OBTAINED THROUGH THE FUNDS CONTRACT PHARMACY FOR REIMBURSEMENT.

INFORMATION REGARDING THE TRUST FUND'S PRESCRIPTION DRUG PLANS CAN BE FOUND IN YOUR BENEFIT BOOK, BENEFIT UPDATES, BY CONTACTING THE TRUST FUND'S INFORMATION CENTER AT (626) 356-1004 OR BY ACCESSING THE TRUST FUND'S WEBSITE AT WWW.OEFUNDS.ORG.

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