

**ILWU-PMA Welfare Plan
 Prescription Drug Plan - Statement of Claim
 Administered by
 Prescription Solutions
 Post Office Box 6037, Cypress, CA 90630**

SEND COMPLETED FORM TO PRESCRIPTION SOLUTIONS AT THE ABOVE ADDRESS

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| 1. Employee complete Part I of this form. | 5. Claims must be filed within 90 days of the date of service. |
| 2. Have your Pharmacist complete Part II of this form. | 6. Please use one form per member. |
| 3. Form must be complete. | 7. Attach original receipt(s). |
| 4. Address must be complete. | |

Part I To Be Completed by Employee Please Print

Employee Name _____ Local _____
Last First MI

Social Security Number _____ Date of Birth _____ Reg.# _____

Mailing Address _____
Number and Street (Apt. #) City State Zip Code

If claim is for dependent _____ (Spouse/Child) _____
Name Circle one Date of Birth

Is claimant eligible for Drug Benefits from any other source? YES NO If YES, from whom? _____

X _____ Student? YES NO
Employee Sign Here Date

With this Signature, I certify that the information I have provided is complete and correct to the best of my knowledge and I authorize the release of any information by the dispensing pharmacist necessary to process this claim.

Part II To Be Completed by Pharmacist for Proper Adjudication:

1. RX #	QUANTITY	DAYS SUPPLY	NEW <input type="checkbox"/>	REFILL <input type="checkbox"/>	PRICE \$	For Office Use:
PRESCRIBER NAME: _____ MEDICATION NAME AND STRENGTH: _____ NDC #: _____ - _____ - _____ Fill Date: _____						A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
2. RX #	QUANTITY	DAYS SUPPLY	NEW <input type="checkbox"/>	REFILL <input type="checkbox"/>	PRICE \$	For Office Use:
PRESCRIBER NAME: _____ MEDICATION NAME AND STRENGTH: _____ NDC #: _____ - _____ - _____ Fill Date: _____						A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
3. RX #	QUANTITY	DAYS SUPPLY	NEW <input type="checkbox"/>	REFILL <input type="checkbox"/>	PRICE \$	For Office Use:
PRESCRIBER NAME: _____ MEDICATION NAME AND STRENGTH: _____ NDC #: _____ - _____ - _____ Fill Date: _____						A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>

****Original receipt(s) must be attached to this Statement of Claim****

Pharmacy Name: _____ NABP Number: _____ Date: _____

Address: _____

Pharmacist Signature: _____ Phone Number: _____