

TEAMSTERS UNION 25 HEALTH SERVICES & INSURANCE PLAN



552 Main Street • Charlestown, MA 02129-1114
 Local phone: 617-241-9024 • Toll Free: 800-235-0760 • Fax: 617-241-5025
 Website: <http://www.teamsterscare.com>



PRESCRIPTION DRUG DIRECT PAYMENT CLAIM FORM

TO BE FILLED OUT BY MEMBER IF USING A NON-PARTICIPATING PHARMACY

Name of Member _____ Tel. No. _____
 (Last) (First) (Middle)
 Address _____
 (City) (State) (Zip Code)
 SS No. _____

ALL INFORMATION MUST BE COMPLETED BELOW

Date of Purchase	RX Number	Name, Strength and Quantity of Drug Supplied	New or Refill	Physician's Name	Patient's Name	Relationship	Amount Paid

IMPORTANT

RECEIPTED BILLS MUST BE ATTACHED TO THIS FORM. THESE BILLS MUST INCLUDE THIS INFORMATION: DATE, NAME OF M.D., NAME, STRENGTH AND QUANTITY OF DRUG SUPPLIED AND AMOUNT PAID.

FUND OFFICE USE ONLY

APPROVED BY: _____ (Total Amount charged by Pharmacy) \$ _____
 _____ Allowed Total Rx Cost _____
 Date: _____
 Net Payment to Member \$ _____